THE HUMAN APPROACH

This book will always be associated in my mind with the late Professor W. Macneile Dixon who helped and encouraged me in the writing of it and looked forward to its publication. This dedicatory note is my humble tribute to the memory of a rare spirit whose friend I had the honour to be.

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PREFACE

I IMAGINE that this book exhibits practically all those faults which are the legitimate prey of the medical critic. "The number of pages allotted to a given topic is disproportionate to its importance; the author continually oscillates between a conversational, colloquial style and a formal, semi-scientific one; it is often uncertain whether he is addressing himself to students, doctors, or the general public; there is much irrelevant matter; there is a great deal of repetition, and there is no index." Various attempts to justify these misdemeanours are made in the text, but in the Preface I must add insult to injury by saying that I committed them on purpose, believing that they increase the usefulness of the book to those for whom it has been written, namely, medical students in general, and students beginning clinical work in particular.

It is intended to help them towards a certain outlook on psychological medicine, with all that that implies, and is an effort, however feeble, to remedy what I believe to be a serious defect in modern medical education.

The chapters not directly addressed to students deal with subjects which I think should be brought to their notice sooner rather than later, and the apparently irrelevant matter as well as the general method and style of presentation must be regarded as my notion of the best kind of jam in which to administer the psychological pill. With that said, I offer them the book in the hope that they will like it and benefit from it. I should gladly welcome and greatly value criticisms from them and from those who have experience of introducing them to the study of medical psychology.

For the fourth time I have to thank my old friend Dr. A. J. M. Butter for willing and expert help in preparing a book of mine for the press and revising the proofs.

I owe as much to my secretary, Miss J. M. Parr, for a certain relentless pertinacity, readily distinguishable from nagging, as I do for her technical skill, and I am very grateful for both of them.

Chapter 1

THE CLINICAL PERIOD

I SUPPOSE that the most significant, if not the most memorable, day of a medical student's career is that on which he finally emerges from the preclinical period, and I have always felt that the occasion of his first introduction to clinical work might well be marked by some appropriate ceremony. The proceedings, which would have something in common with coming-of-age celebrations, could be made interesting and varied and might suitably conclude with an address, the speaker being careful to delay his remarks until a certain tranquillity, apt to be mistaken for receptiveness but in fact more resembling mild coma, had descended upon the happy party. I have never assisted at such a function, nor do I think it likely that I ever shall, but this chapter is written largely as an imaginary address to such an imaginary audience.

Hitherto you have been concerned with frogs, dogfish and suchlike, and later with anatomical specimens and preparations of various kinds, culminating, so to speak, in the subjects in the dissecting-room. You have worked in the chemical and physiological laboratories, and you have also, I am sure, done a great deal of book work, memorising much hard fact and many complex theories.

You are now starting out upon something very different, something which will henceforth be the sole business of the professional lives of most of you, namely, dealing with human beings who are injured or sick. You will naturally, therefore, regard the present stage of your medical careers as one of great importance and significance. You will not require to be told that living men and women and children are more complicated and interesting things to study than worms or dogfish or corpses. Further, the object of all your previous studies is now becoming increasingly clear. That object is the prevention and cure of disease in human beings, and it is attained by the practical application of what you have learned and what you will yet learn.

The practical application of scientific knowledge to cure or relieve disease in a patient is clinical medicine. Your studies have thus become more complicated and more immediately related to their final goal.

When a schoolboy becomes a university student, his first business must be to grasp the difference between learning a lesson and getting up a subject. In similar fashion a medical student, on emerging from his preclinical stage, must realise the immense step he is taking from his book and laboratory work to their practical application at the bedside. The supreme importance and difficulty of this step is, of course, due to the introduction of an entirely new factor—namely, human nature. Your patients are, like yourselves, living people with personalities and minds. Whatever those words may mean, your own experience and commonsense will suggest to you that they are rather important parts of the human organism. You will rightly think that any dealings with a patient, whatever their nature and purpose, which ignore these attributes, are certain to be incomplete, and liable to be unsatisfactory even so far as they go, and you will expect to receive instruction in due course upon the proper understanding of, and the medical attitude towards, those qualities in your patients which chiefly distinguish them from the beasts of the field.

So far you have dealt exclusively with matter which is subject to clear-cut physical and chemical laws. The success of an experiment in the laboratory reflects no credit upon you. It cannot help succeeding, provided that you fulfil the necessary conditions, and it is to your discredit if you fail to do so. You cannot alter the facts connected with the sphenoid bone, and if you choose to ignore them nobody is any the worse except yourself. Nothing you do or fail to do can disturb the equanimity of the subject in the dissecting-room. And now the whole position is transformed by the sudden introduction into the material with which you work of two of the most mysterious and incalculable things in the world—human nature and human conduct.

In the past you may, on occasion, have expressed with some freedom your opinion of the " part " or specimen on which you were working, and you always had the last word. Whatever you may have said in your wrath about the brachial plexus or

the medulla oblongata, these structures have never been known to show any reaction to your hard words. They are incapable of lying, sulking, deceiving, or announcing their opinion of *you*. Your new " clinical material," however, is prone to do just those very things, and many others like them. It you doubt it, or even if you do not, you should sit, suitably disguised, for half an hour in the waiting-room of any hospital out-patient department. That half-hour would be more profitable to you than an average week of ordinary " clinical instruction."

Your surprise may perhaps be equalled by your disappointment at the quantity and quality of the teaching which you are likely to receive on the significance of the human element, for that is what it amounts to, in your patients, or on how to recognise, study, understand or deal with it.

Admittedly there are many things—an understanding of human nature being one of them—which you cannot adequately learn from a text-book, a course of lectures, a series of demonstrations or, indeed, any form of " teaching," despite the best efforts of both teacher and taught. Your teachers know this perfectly well, of course, and can hardly be blamed for limiting their efforts to the teaching of their particular branch or subject as well as they can, and leaving it at that. They might possibly agree that this results in your missing something, but unfortunately the whole general trend of modern medicine is making it increasingly easy for them to believe, and to teach, that the omission, if it exists, is of no great importance. This, naturally, makes it all the harder for you to realise that a patient cannot be fully described or understood in terms of chemical reactions and pointer-readings, nor does it encourage you to modify and expand your earlier methods of approach.

It can also be urged, very plausibly, that all this stuff about mind and personality and understanding human nature surely comes into the domain of psychological medicine. It is, therefore, the business of the teacher of that subject to decide what his students should know about this branch of it, and to see that they are taught it. Whether it is fair to put all the responsibility upon the teachers of psychological medicine or not, they must certainly accept a large share of it, and it must be confessed that they—I should say we—are far from having made a satisfactory attempt to discharge it.

from the point of view of a young man among his fellow beings as well as from that of a potential doctor among his patients. He must begin with the study of normal human beings, and he must use, in the first place, the language of every day. Now, having surveyed our task, let us get ahead with it.

I think our first step must be to disabuse our minds finally of the notion that a "disease" is something which a patient has "got," much as one "gets" a packet of cigarettes or a theatre ticket. Let us suppose that you are walking round a golf course with a stranger whose strokes you have every opportunity of observing. In a very short time you may reach the conclusion that he is a thoroughly competent golfer, and you will not change your opinion on learning from him later that his handicap is four or five, that he has no real hope of ever reaching championship class, and that he badly needs a series of lessons from the pro. Golf, in fact, above a certain standard, is simply a matter of increasingly efficient adjustment of oneself to various co-ordinated movements plus constant education of one's judgment and increase of one's experience. Many thousands of men are obviously competent and some are brilliantly successful, but a one-hundred-per-cent successful adjustment never has been and never will be attained.

In precisely the same way, physical and mental health and efficiency are to be regarded as depending, above all else, upon the degree to which we succeed in adjusting ourselves to life.

This conception of adjustment of varying degrees of adequacy leads us directly to the great fundamental truth of all medicine, namely, that bodily and mental adjustment are so intimately associated, and indeed united, that it is impossible to make any serious and effective study of either of them separately It is a universal principle that a physical maladjustment implies a mental one, and vice versa, but there are, of course, very many cases of both bodily and mental disorder in which it is not obvious or of *immediate* importance. These cases are not our present concern, nor shall we discuss those in which the mental maladjustment, though obvious enough, is clearly secondary to and dependent upon the physical one. Such cases abound, as can readily be verified by observing a few sufferers from deafness, influenza or dyspepsia, or by talking, or rather listening, to a golfer after a bad round. Further, such maladjustment

can, and often does, interfere very seriously with convalescence from illness, injury or operation, and sometimes tends to create a vicious circle.

But our present business is to study simple and primary mental maladjustments. We shall learn in due course that they are not only constantly associated with physical changes, but are repeatedly the unrecognised and untreated cause of obviously and acutely disordered function in any and every organ of the body. The amount of avoidable suffering caused and chronic irrecoverable illness produced by directing treatment only to the badly functioning organ, while ignoring the causative underlying mental maladjustment, is incalculable. There is nothing wrong with modern medicines and procedures ; quite the reverse. But your car will not run well, however expertly you attend to the engine, if you ignore the fact that the brake is on. It was the best butter with which the March Hare lubricated his watch, but it did no good, and it would have been simpler, wiser, less expensive and more effective if he had first tried winding it.

We must not try to run before we can walk, and we must begin by studying these mental maladjustments in their earliest and simplest forms, and discovering how the mildest and most trifling of them manifest themselves, not in any serious abnormalities of mind or body, but in the multitude of minor tendencies, characteristics and reactions which go to make up personality and to influence, if not indeed to determine, conduct.

I suppose that one of a student's earliest impressions of hospital patients, after entering on his clinical period, must be that, taken as a whole, they are unreasonable beings. Apart from a minority (usually those who are dangerously ill) who show an amazing patience, cheerfulness and fortitude, they somehow don't seem able or willing to carry out advice, to understand instructions, to grasp explanations, to say what they want or to listen to reason. If one points out that these are among the usual characteristics of sick people, and that one must therefore make allowances, there is the obvious reply that the relatives are ten times worse. If, from that consideration, the student passes by easy stages to a study of his colleagues, his teachers and finally—and reluctantly—himself, he may arrive

at the perfectly correct conclusion that nobody is a reasonable being. When he has got so far he will have grasped the essential difference between patients and specimens, between the hospital ward and the physiological laboratory. He may point out, however, that nobody wants patients to be logicians or automata, but that there is surely no need for this patient to say that your necessary enquiries are an insult, or that one to yell the place down over a mere scratch, or the other one to leave in a rage because you say her child's tonsils should be removed. Well, there is certainly no "need" for these reactions or the infinity of similar ones you may observe daily, but let us ask just how they differ in their essence from the reactions of your friends and yourself to situations which are of the same order of importance to you as a visit to hospital is to the patient. I wish you could have seen yourself at that Committee meeting the other day. They tell me that at the end of your speech you were so excited that you forgot which resolution it was that you were supporting, and one member said he was convinced that honesty is the best policy just to see if you would contradict him, which you obligingly did. I hear, too, that your recently qualified friend cut such a pitiable figure in the witness box last week that counsel had something smart to say about physicians healing themselves, which got a good laugh.

If you want instances not quite so near home you need only listen to the average discussion on political or religious matters, or, for that matter, to the Mother of Parliaments at one of its less distinguished moments. You will find in these instances the very same reactions as those which you find it so hard to suffer gladly in patients and their relatives, with two differences. Firstly, they are often rather more obvious and crude in patients because impaired health and indifferent education often colour the picture, as they lead to lessened control. Secondly, a certain amount of education and training enables the average person in public or professional life to camouflage his irrelevancies, prejudices and illogicalities more successfully than the average hospital patient. He covers them over, by means of processes which we shall discuss fully later on, with a veneer of reason, logic and respectability. So skilfully can this be done that many a man whose conduct is every bit as

unreasonable as that of anyone else is honestly convinced that he is the last remaining home of sound commonsense in an unreasonable and fat-headed community.

Then there are the people who are never wrong, or at least never prepared to admit that they are, and the people who know just where everyone else is wrong, and what should be done in every conceivable situation. On the other hand there are the people who seem to spend their lives apologising for their own existence, the people who never know their own minds for ten consecutive minutes, and many others. And there are the maddeningly " dumb " people, the aggressively " hearty " ones, the censorious ones, the insincere ones, the ones who cannot see the point, and, perhaps worst of all, the ones who unceasingly explain their position and justify their conduct till their hearers are bored stiff. You met representatives of this happy band long before you came to hospital.

If there is not a special place in Heaven set apart for those who never said " Take my own case, for example," it can only be because there are not enough of them to make it worth while. An entire essay could be written about this most popular, and perhaps most annoying, of human pastimes.

The man who indulges in it is not by any means practising that confession which is good for the soul, nor is he trying to give his hearers helpful information in the hope that they may regard him as a good example or an awful warning and, in either case, profit by his experience. He is doing something much more selfish and less dignified. He is explaining away, or concealing, or distracting attention from some weakness or failure or folly or ineptitude by pathetic attempts to convince others—and, especially, to convince himself—of his courage and resource, of his brave struggle against hopeless odds, of the cruelly hard luck he has had, of the unfair treatment he has received, of his skill in thwarting malicious competitors, or of the success he would undoubtedly have achieved had " things " been different. He has much in common with a well-known variety of golfer whose forum is the nineteenth hole. He is like a man on the roadside in front of a gate which he cannot open, spending his entire time and energy in desperate efforts to explain to the passers-by his inability to open it. His delightfully varied and mutually inconsistent explanations are a first

lesson in medical psychology. A selection of them follows, with the technical name of each appended, for reference later.

There isn't really any gate at all; he has just stopped to admire the view. (Repression.)

There may be a gate, but, if there is, it's very wrong to go opening gates; in fact, it's definitely illegal. Besides, he has promised his wife to be home by six-thirty, and he would rather be a man of his word than open all the gates in the country. Thank God he still has a sense of duty. And, if it comes to that, why should he give in to idle curiosity by opening the gate? He knows he has many faults but, thank God, he can still use self-control, etc., etc., etc., *ad lib. et ad naus.* (Rationalisation.)

Speaking as a hiker and scoutmaster he is all in favour of opening the gate, but speaking as a farmer and local magistrate he is all against it. Speaking as a man? That's impossible. He will speak in one capacity or the other, depending on how you approach him, but not in both at once. (Dissociation.)

He is waiting till sunset, when an ingenious apparatus of his own invention, which works on the principle of the well-known seven-league-boots, will waft him triumphantly over the gate and all other obstacles without the least exertion on his part being required. (Phantasy.)

Will you please look at this blister on his heel, feel his pulse, observe his tremor, study his paralysed arm and listen to his labouring heart? All these are the direct consequences of his devotion to duty; is it fair or decent to expect more of him? Besides, have you noticed the gate? The latch is immovable, the hinges are thick with rust, the bars are of cast-iron, and the whole thing weighs at least half a ton. It's all very well for you who have never known a day's illness, and can readily obtain hammers, oil-cans and ropes, but when he thinks of himself, all alone . . . . . the rest is lost in a flood of noble emotion. (Hysterical reactions, such as the "flight into illness," and the "poor little me" gambit.)

These are a few of the reality-dodging devices which you must become able to recognise, not merely in others, which is comparatively easy and quite amusing, but in yourself, which is very much the reverse. It is hard to overcome the conviction that you are "not that kind of person at all," and to realise that you—even you—are just as ready as anybody else

to avoid facing facts when it suits you, and to think yourself into believing that you are doing nothing of the sort.

Nevertheless, if you won't deal with the situation, you may be sure that the situation will eventually deal with you, and the punishment will fit the crime with mathematical accuracy. If you insist on standing beside the gate telling your sad story to all who pass by, you will find that in due course you will come to be regarded as a feature of the landscape, and that you will receive no more serious or prolonged attention than does the old-established and eccentric street beggar who has frequented his special " pitch " for years. You may, of course, like the Ancient Mariner, be lucky enough to find someone, every now and then, who " cannot choose but hear " when you explain your position to him and invite him to take your own case for example, but this is not probable nowadays. It is much more likely that with increasing years and fatigue you will become someone very like Lewis Carroll's " aged, aged man, a-sitting on a gate," and your conversation will be much on his level, though less amusing.

As I have already said, we must look at the psychological basis of these reactions but, quite apart from the difficulty of this study, it is far more important that you should observe and recognise them than that you should be able to theorise about their origin. Far from being symptoms of " disease," they are common, in different forms and degrees, to all of us, doctor and patient, teacher and taught. They are present in every social, professional and personal relationship, and we must be able to recognise them in ourselves before we can hope to understand them in others.

It is important that you should do so, because the ability to recognise them, to allow for them, and to deal with them in your patients is the secret of " the human approach." That approach does not clash with the objective scientific one, though it often transcends it. There is no human situation which it does not simplify and illuminate, and there is no surer foundation for your success, in the best meaning of that word, in any branch of medicine or department of life.

Chapter 2

" CASE-TAKING "

To write a book for medical students of which an early chapter was not entitled " case-taking " would be a most serious departure from tradition. As the contents of this chapter certainly make such a departure, I feel constrained to adhere to orthodoxy in its title.

I think that almost every medical man can recall with lively emotion the first occasion on which, as a student, he was faced with the task of making a clinical examination and report of a previously unknown patient, and I imagine that he felt at the time—and perhaps ever after—that he was more to be pitied than his victim.

It all seemed easy enough when the house physician or the Chief was doing it, but they had vanished, as also had his self-confidence, and this patient was different and more difficult anyhow. The austere figure of Sister in the offing was a disturbing rather than a reassuring factor, nor was his equanimity restored by the uneasy consciousness that he was carrying a book on clinical methods in one pocket and a printed schedule or questionnaire in the other. Pulling himself together and nervously gripping his stethoscope, he advanced to the bedside in a state of mind which must have had much in common with that of the Colonel whose caddie abandoned him in the bunker, leaving him " alone with his mashie and his Maker."

And yet it is in some measure a student's own fault if he finds his first introduction to " case-taking " a disconcerting experience. He will devote infinitely careful preparation to every detail of his appearance, speech and manner before an interview at which he hopes, let us say, to placate an examiner, to extract a testimonial from a chief, to negotiate a financial transaction with a colleague, or to conciliate an offended acquaintance. Why, then, should he so often abandon all forethought in this matter of " case-taking," and enter upon it with little idea of what to say, still less of how to say it, and dizzily preoccupied with the effort to remember the functions

of the cranial nerves without having to look them up in the book?

The obvious answer, which shifts a good deal of the blame from himself to his teachers, is simply that he has never been taught anything more than what we may call the medical technicalities of the job. In the hope of simplifying his task, and the certainty of making it more interesting and fruitful, let us regard it as the approach of one intelligent being of good-will to another, and discuss a few of the most elementary principles of human intercourse. Of course they are psychological principles, but if you ask me why they are never mentioned in any book on medicine or psychology I cannot tell you. It may perhaps be because they are too obvious, superficial and commonplace. On the other hand, it might possibly be because the profoundest psychology is at a loss to explain them adequately. However that may be, it is certain that they are equally applicable whether one is dealing with the old or with the young, with the sane or with the insane, with the healthy or with the sick, and are the basis of all effective contact with patient, with colleague, with stranger and with friend.

The most important point of all is one of which, I am glad to say, very few students need to be reminded. It is simply that when you interview or examine a patient, the splendid voluntary hospital tradition that the patients are its guests and are to be treated as such is, for the time being, in your hands. What may happen to that tradition in the full light of the wonderful new day whose earliest dawn we are all at the moment observing with mixed feelings, is a matter on which we need not speculate. For the present the tradition remains, and it calls for loyal observance whether the patient be in-patient or out-patient, male or female, old or young, drunk or sober. It is true that patients sometimes need to be "told where they get off," and also that a certain firmness, not to say sharpness, in manner is occasionally of great help both as a diagnostic and a therapeutic agent. These procedures, however, need not be inconsistent with the principle mentioned above, and, in any case, it is very rarely, if ever, the business of the student to apply them. You will acquire the necessary technique in due course, and in plenty of time.

Next, you should constantly remind yourself that your patient is neither in a witness box nor in a crèche. Let us take these unpleasant alternatives in order. You are going to ask the patient all sorts of questions and to concoct from his replies something which you will doubtless call a " history." But it is not a history of objective fact. It is a history of the patient's subjective feelings and of his view and interpretation of various facts and experiences. That is what you will get from the patient, and a very useful and essential thing it is, provided that you do not mistake it for something else. If you question your patient in the style of a learned counsel dealing with a hostile witness, you will get just what you deserve,—nothing of any value whatever. Your object is, or should be, to ascertain what the patient feels and believes. It will often be obvious to you that his beliefs are ill-founded, his views self-contradictory and his statements opposed to probability and indeed to fact, (and, by the way, it is by no means only of psychotic and neurotic patients that this is true) but it is not your business at this stage to point out his mistakes, still less to urge him to " speak the truth." You might just as well adopt the legal phraseology along with the inquisitorial attitude and tell him to be very careful and to remember that he is on oath. What you are trying to obtain to begin with is the whole story as it appears to the patient. It can and should be " checked up " by interviewing relatives and by other means in due course. Few things are more useless—and infuriating—than a " case-history " which is a coagulated jumble of the patient's statements, his wife's reminiscences, his son's theories, his daughter's explanations, the doctor's opinions and the case-taker's findings all mixed up together ; fact, speculation, suggestion, rumour and invention " in one red burial blent."

On the other hand, it is useless to frame your questions as if the patient were an unintelligent child of six (unless, of course, he happens to be one), and it is quite unforgivable to deal with his questions by making statements which are incomprehensible to him or giving explanations which you know to be medically absurd. There are few more difficult things in medicine than to explain some pathological process or surgical procedure clearly and convincingly to the average hospital patient. You should avoid detail as much as possible and aim

at making your explanations, however incomplete, reasonably accurate as far as they go. It is better not to embark on an explanation at all than to offer one which outrages the facts of anatomy and physiology as well as your own medical conscience. If you make it a rule never to assume that your patient, whatever the degree of his education, is your inferior in intelligence and commonsense, you will be spared the humiliating discovery that he is sometimes your superior in mental alertness and occasionally in good manners.

It is folly to ask a question to which nothing short of a pamphlet or essay could provide a satisfactory answer, and it is something worse than folly, having asked a question, not to await a reply before asking another one. To pay so little attention to a patient's answers as to ask him the same question twice is usually sufficient to banish all hope of gaining his co-operation. It is evidence that you are not taking him seriously and you can hardly expect him to take you seriously in return. You can confirm the truth of this by recalling your own reactions when you were the victim of such treatment, as most of us have been from time to time in everyday life.

Never refer to a baby as " it " when talking to either of the parents—especially the mother. If you have neglected to ask at the beginning whether the infant under discussion is a boy or a girl, the error can be rectified and often concealed in agreeable fashion by asking the mother what the baby's name is.

It is true that the baby's name has nothing to do with the health of the mother, or of the baby, and that there is no need for you to incorporate it in your " history." Nevertheless, the apparently trivial and irrelevant enquiry is abundantly worth while to make, for the reason, among others, that it may have an incalculable effect in producing a frank and co-operative attitude in the mother. I have repeatedly found it make, like Shadbolt's thumbscrew, " all the difference between stony reticence and a torrent of impulsive unbosoming that the pen can scarce follow."

The average patient has every intention of speaking the truth, but it is the truth as he sees it, and you must always bear in mind that what is true for him is not necessarily true for you, and vice versa. Further, the patient has come to relate the

experiences and troubles and pains which are his and nobody else's, and unless he has achieved good organisation and control of his emotions, a sense of proportion and other qualities of character, he will be very prone to dramatise the situation in the most vivid fashion. Patients will often say, with earnest and sincere conviction, that they have not closed an eye for six weeks, that they have vomited material of practically every colour in the spectrum, or that the blood from " a terrible wound " left the room ankle-deep in gore. Patients rarely go in for half-lights. Everything is either very black or very white. Their sick friends look ghastly or " corpse-like," every emergency is " a matter of life and death," and the loss of a senile great-aunt is " a terrible shock."

Such patients are not trying to deceive you ; that is just the way they see things. You should note these tendencies, do what you can—and it is a great deal—to minimise them by a quiet, friendly, matter-of-fact attitude, and see to it that your " history " distinguishes clearly between the patient's " truth " and yours ; that is to say, between objective facts and the patient's version and interpretation of them.

Now, apart from and in addition to all this, patients will, of course, mislead you repeatedly in various ways and from various motives. Conscious calculated malingering is extremely rare, and deliberate untruth on points of fact is also uncommon, unless the patient's own emotions or reputation or self-esteem are directly involved. It is here that attempts at deception begin, and sometimes they have become so habitual and automatic that they can hardly be called really conscious, or, at least, purposeful. They take several forms, the technical psychological names and explantations of which you will doubtless learn in due course. One is the simple omission of the painful or discreditable fact from the story. Thus a patient may tell you that he was ill four years ago with a broken leg, and two years ago with pneumonia, but may refrain from adding that he was also ill three years ago with gonorrhœa. If the omission is discovered he will explain either that he forgot about it or else that he thought it unimportant and didn't wish to make his story too long, as he knows how busy you are. It is quite likely that he honestly believes that the " explanation " which he offers is the true one. For that matter, it is

very possible that the omitted point may have no direct bearing on his present condition. The significant thing is not the point itself but his omission of it.

Another form of deception is the almost universal tendency to rearrange the details of some past event so that it shows the narrator in as favourable a light as possible. Thus a patient is much more likely to tell you that he left his employment because he was tired of it, or because he was unfairly treated, or because he had a row with the foreman, than he is to admit that he was dismissed for bad timekeeping or petty dishonesty.

But the great general cause of all misunderstanding and deception, serious or trifling, conscious or unconscious, lies in the simple basic fact that practically every hospital patient at the first interview, and long afterwards for that matter, is in some degree apprehensive, embarrassed, resentful or "nervous" in the popular sense of that word. People in such a state resort automatically to evasions and lies, and their statements are no more to be taken at their face value than is a frightened child to be regarded as a reliable witness to fact. It is true that the nature of the questions asked, and still more the manner in which the questioner phrases them, as well as his general attitude, demeanour and tone of voice, can do a great deal to ease the situation, as anyone can verify by speaking to the first frightened child he sees, but the fact remains that frightened people evade simple truth and painful reality almost as a matter of course and often with astonishing ingenuity.

All the irrelevant, evasive and misleading replies of patients illustrate, in some degree, the so-called psychological "mechanisms," and can be expressed in psychological terms which you will duly learn. Sometimes they are of immense diagnostic value as being the earliest symptoms of some serious nervous or mental disorder, but the important point at the moment is that the student should recognise their existence and realise, too, that they are by no means the special characteristics of patients, but that he can find them exemplified in infinite variety and degree in the social contacts of every day.

The tendency to defend what has not been attacked is a very common and highly significant one. You cannot be long in an out-patient department without hearing some patient indulge in a voluble autobiography, rehearsing her blameless life,

heatedly upholding her virtues and, in general, defending her character from aspersions which nobody ever thought of casting upon it. As a simple exercise at this stage you might well consider for yourselves what inferences might be drawn from such a performance.

If a patient on entering my consulting-room were to announce to me with some warmth that he was an honest man, was well respected by all who knew him and had not stolen a single one of the silver spoons in the waiting-room,[1] I should make the only possible reply: "My dear Sir, such an idea never entered my head. I wonder what can have put it into yours!"

An almost interminable garrulity which seems to ramble around at constantly increasing distance from the relevant points is so sadly common that perhaps it can hardly be regarded as of special significance. It has been far too often portrayed in literature and on the stage for anyone to have the slightest difficulty in recognising it. The only advice that can be given here is that those who combat it most successfully—and I have magistrates in mind, even more than physicians, at the moment—have no doubt that the correct course is to suffer in silence until patient or complainant comes to an end, either from lack of matter or more usually from sheer physical exhaustion. Certainly it pays to obtain an assurance from a patient that he (or perhaps I may be forgiven for saying she) has really said everything she wants to say before you proceed with your questioning or examination.

If you are at all observant you will notice repeatedly that the emotional state of many patients seems quite inappropriate to the story they tell. For example, a patient apparently suffering from, or threatened with, some tragic disability such as deafness or blindness or paraplegia, may present an air of bland indifference which is hard to reconcile with the state in which he believes himself to be. On the other hand, there may be intense emotional upset over a bodily injury so trifling that one is surprised that it brought the patient to hospital at all. Sometimes, too, a patient will relate difficulties and troubles with smiles, giggles or even repeated hearty laughs as if the whole thing was the best fun in the world. These, and many other

[1] There are no silver spoons in my waiting-room, now.

inconsistent emotional reactions are of the very greatest psychological importance and should be observed and noted with care.

There is only one answer to the question which is very often asked : " How should I speak to a case of so-and-so ? " The answer is : " I have not the slightest idea." If you bring a given patient to me I may very soon be able to tell you in general the attitude I should adopt towards him, but I should have to add that what would be the right attitude for me would certainly be the wrong one for you, for the simple reason that we are two different people. It is clear that a patient might, for example, respond to a cheerful, man-to-man, hail-fellow-well-met air in a student which he would regard as an undignified attempt at facetiousness if it came from an older man. On the other hand, a patient might accept advice or censure from a senior, which he would not tolerate from someone his own junior. One must therefore realise that each situation is a law unto itself and is not to be governed by any rule of thumb instructions, but only by the one golden rule, namely, that you are to be simple, sincere and natural. If you can be all three at the same time you will have a flying start in your investigation of every patient you are called on to examine, and will soon realise how much is to be learned from the matter, and still more from the manner of his replies to the right questions put in the right way. But before you pass on to your physical examination and diagnostic procedures remember that there is another important and strangely neglected source of information from which you must always try to glean what you can, namely, the trained and intelligent use of your eyes—your powers of ordinary unaided observation.

It is remarkable how much information is missed, especially at a first interview, which could have been gained by an intelligent, though admittedly quick and perhaps superficial, observation of many small trifles in a patient's behaviour and personal appearance. It is almost a commonplace in novels and detective stories that a patient's hands furnish a key to his state of mind, but I have never read in a medical book that it is wise, when " taking a case " to observe whether the patient is fidgeting with his hands, clenching his fists, twiddling his fingers, holding his thumbs and so on, and whether his

finger nails look as if they had been bitten, neglected or reasonably cared for. Quite apart from your physical examination of the patient, it should become—and will become, once you realise its importance—almost second nature to you to observe and draw inferences from the patient's general appearance, the shape of his mouth, the alertness or dullness of his expression, the presence or absence of what used to be called "stigmata of degeneration" such as obliquely set eyes, unsymmetrical ears, abnormality of their lobes and so forth. It is much better to note for yourself before you start your physical examination, that a patient is trembling or sweating, or short of breath, or minus a finger, than to discover it with audible surprise when you are half-way through.

The nature, suitability and tidiness of a patient's clothing is, of course, another field for observation and helpful inference, as also may be any of the trifles that crop up in an interview. There is nothing of the Sherlock Holmes in all this. It is an essential and commonsense preliminary to any more thorough and scientific investigation of the patient's illness. Of course if a student ignores what is under his nose he may, on occasions, be fair game for someone who does not. A student once told me that a patient of clean and healthy appearance, obviously disciplined manner, and quiet direct speech, with tattoo marks on his arm protruding from his sleeve, was probably a clerk. When my alternative suggestion that he might have been a sailor was found to be correct the student was greatly impressed, and asked me at the close of the clinic how on earth I knew!

Now all the foregoing are simply a very few of the infinite number of points attention to which will make a case-report even by an inexperienced student a sound and helpful document as far as it goes, instead of a stilted futility. The more they are kept in mind the more likely are you to succeed in achieving at the all-important first interview that human approach to your patient which is the one sure road to a broad and balanced view of his illness, a sound diagnosis, and an intelligent line of treatment. They are, nevertheless, only the merest and most tentative preliminaries—perhaps that is why no book for medical students condescends to discuss them—and you must never regard or use them as a short cut and as a

means of doing without that careful systematic examination of the body and mind of the patient without which you will get nowhere. That danger has always to be pointed out in expounding this matter of the human approach to medicine, and discussing sane everyday psychology. It must not be forgotten that a physician with years of clinical experience behind him cannot help making the first interview with a patient look a far simpler matter than it really is. Most of his conclusions are based on and supported by that experience, and though they may appear to the student to be reached almost intuitively by the observation of some trifle, they have in fact, been placed by the physician against a background of scientific training and experience and reading, and passed as consistent therewith before he utters them. It is necessary therefore, to emphasise that nothing that has been said in this chapter, or in this book, about the approach to a patient, perfectly true and vitally important though it all is, lessens in the slightest degree the obligation on the student to go through the drudgery (if he so regard it) of that steady, methodical study of clinical methods and medical psychology which alone will fit him to make systematic investigation of the problems which his patients will so constantly present. With that said, it is a question of using scientific methods "as not abusing them."

Important though this warning is, there can be no doubt that those who have "gone all psychological" to the detriment of their modern scientific medicine are infinitely outnumbered by those who have gone all mechanical and ignored the human factor altogether. Let us see the results of this attitude at the next stage beyond "case-taking." A patient arrives at the out-patient department in a pitiable state of terror which she explains by saying that she is convinced that she is suffering from venereal disease. A "history" is promptly taken, of which it need only be said at the moment that very often it omits all the really relevant facts. It is usually a brief and perfunctory document, because such a case affords a splendid opportunity for the exploitation of that most dubious of all medical aphorisms: "Exclude the organic before diagnosing the functional." In actual practice this often reads: "Work yourself and your diagnostic instruments and your special departments and the patient to the limit in the attempt to

find some shadow of excuse for your refusal to admit the possibility of the functional." Anyhow, the history states that the patient shows " no signs." Her obvious and outstanding symptom of acute anxiety is often ignored, as also is the fact that her mental state would remain unjustified and unexplained though she were riddled and ravaged by venereal disease beyond recognition or hope. At this stage it would be well for the student were he to visit the appropriate department and observe for himself the demeanour of patients really suffering from venereal disease. But he does not do so. Instead he watches the hunt for the organic proceeding with ever-increasing fervour till it reaches its disappointing end—a mass of laboratory reports, all marked " normal " or " negative." The patient is then told the glad tidings that it has been proved beyond doubt that " there is nothing wrong " with her. " But," she bleats plaintively, " I'm still afraid that I've got it, and I'm feeling dreadful about it." " Well, you must just forget about it ; the tests prove that you are talking nonsense."

Similar tabloid tragedies are enacted daily at every hospital in the country. To wave a " W.R. negative " report at the patient is not really the appropriate treatment for morbid anxiety or an obsessional state, and does little to decrease the difficulties of subsequent treatment when the patient drifts in due course to the department of psychological medicine.

Chapter 3

THE LANGUAGE OF SYMPTOMS

In the preceding chapters an attempt has been made to disabuse the student's mind of the notion that a disease is something which a patient has mysteriously "got," and that along with each disease go a number of things called symptoms which are capable of logical or mechanical explanation and are to be carefully memorised, much as we used to learn the names of the counties of England or the branches of the external carotid artery.

It has also been pointed out that, whatever the future may bring, the present-day teaching in our medical schools does little or nothing more than pay a perfunctory lip-service to the ideal of educating the student beyond this view, and teaching him the supreme importance of the personality and mental make-up of each individual patient and the profound significance of the psychological factors in his medical history. If that ideal could be attained we should regard a patient's various symptoms not merely as so many different faults in a machine, but as combining to form the reaction of a living human organism to internal conditions and external circumstances.

From that starting-point we should naturally proceed to investigate not only the comparatively superficial question of *how* they arose, but the far deeper and more fundamental one of *why* they arose. It is quite true that much medical research work is not content to stop at the *how*, and concern itself seriously and successfully with the *why*, but for the average student beginning clinical work, the point is a vital one, and is very much more than a distinction without a difference. The "how" is the simple obvious rationale of the thing. The engine squeaks "because" there is friction between two working parts, and that is how the noise is produced. Quite true, but if you really intend to go into the matter and are not content merely to "bang in a spot of oil" and carry on till next time, you will surely proceed to ask *why* there should be

this friction, which is a much more important thing than the squeak. Has the temperature caused expansion, or is the general design faulty, or is the load too heavy, and so on. It is largely a matter of degree—of how thoroughly into the question you are prepared to go, and of how willing and able you are to take a broad view of the whole matter and to correlate its various aspects. Above all it is a question of how clearly you realise that an answer which only goes one little obvious step below the surface is really no answer at all. Once we have realised that, we shall not rest content with learning lists of symptoms by heart, but will rather ask what is the essential significance of symptoms, what do they really indicate, what is their purpose, what, if anything, are they expressing and trying to tell us?

Let us keep clearly in mind that we are talking about symptoms in general, or rather, the symptom group, taken as a whole, which any given patient presents. The first thing to be done if one is ever to understand the full meaning of symptoms, is to discard once and for all the utterly fallacious distinction between " bodily " and " mental " symptoms.

There are few things more astonishing, and none more tragic, in medical education than that this arbitrary, unscientific and indeed meaningless distinction should be accepted unquestioningly and taught as a kind of clinical axiom to generations of students by those very teachers who write so learnedly about psychosomatic unity. Some such question as the following could most profitably be set in an examination paper on physiology or medicine. " Define and distinguish ' bodily ' symptoms and ' mental ' symptoms. Into which class would you put each of the following, and why? Headache, restlessness, examination-diarrhoea, fainting, blushing, the vomiting of pregnancy, pain, stammering, weeping, dysmenorrhoea, anorexia, insomnia, impotence? " The list could easily be made as long again.

If we cling to the idea that " bodily " and " mental " symptoms are entirely different and separable things, then all talk about symptoms having a meaning and trying to convey it becomes so much nonsense. But the idea is fallacious, and any apparent exception to the rule that the two are inseparable lies in the opposite direction to that in which the student might

expect to find it. It is perhaps possible, in theory, to conceive of a " mental symptom " unaccompanied by any discernible bodily changes, but one can hardly deny that a fractured femur has some effect upon its owner's state of mind. That altered state of mind, whether we ignore it or not, is an important member of his symptom group, demanding its share of attention and treatment.

It may not be out of place here to remind the junior student that the commonest of all symptoms, and infinitely the most important one to patients—namely, pain—is an entirely subjective experience. Its location, its duration, and particularly its intensity are all matters for which we have to take the patient's word, and it is never easy and often impossible to obtain satisfactory confirmation of what he tells us. " There was never yet philosopher who could endure the toothache patiently." No, and the fact that he had a carious tooth with a root abscess did not turn his pain into a " bodily symptom." Body and mind both have a place, varying in prominence, of course, in every symptom and in every disease, juggle with those words as we may, down to a cut finger and up to a broken heart.

Now if we are to interpret symptoms aright and discover their meaning, we shall have to learn their language. Until one has learned the rudiments of a foreign language, such as its alphabet, its standard constructions, its pronunciation and a simple working vocabulary, one gets nowhere. But much more than this is needed if one is to become really at home in the language. One strives not merely to read the words correctly but to understand their meaning fully, and to acquire such mastery of the language as will result in an enjoyment of its literature and an appreciation of its poetry. Your early clinical work is designed to familiarise you with the absolutely essential rudiments of the strange new language of symptoms which you have begun to study. You are trained in the use of fundamental diagnostic instruments and procedures, and unless you learn to make easy, natural and accurate use of them you might as well be attempting to study a foreign language without dictionary or grammar. You also receive —or are supposed to receive—lectures on elementary medical psychology at the beginning of your clinical period, and these

are—or should be—intended to remind you from the outset that there are unexplored complexities and possibilities ahead, and that even the very rudiments of medicine are more than a mechanical learning of its alphabet, but are inseparably bound up with "the psychological factor." You are faced with that factor, whether you like it or not, from the moment that you set foot in the hospital, and if you are ever to master the language of symptoms you must train yourself to be receptive to the information which the patient's psyche and soma in combination have to offer. It is for your teachers to show you that these two sources of information are not independent of, or isolated from, each other, but that on the contrary they are complementary and indeed inseparably united.

But here a serious difficulty presents itself to the student. It is all very well to say that the patient's soma and his psyche make a united contribution to his symptom-picture, but the contribution of the former usually appears to be much the more obvious and important of the two, and is certainly the more readily explained and understood. A patient has either got a fractured femur or he has not ; an X-ray will settle the question. The symptoms following failure of cardiac compensation form an ordered train of physical events which can be logically inferred from first principles. It is really a matter of mechanics, and how does psychology come into it? Well, these events are occurring in the body of a human being, and that is how psychology comes into it, but without commenting further on the examples we may admit the difficulty at once. The psyche's contribution to any symptom picture is usually the harder for the student to appreciate, for the excellent reason that he is totally unfamiliar with its methods of expression. He has been familiar, in a practical sort of way all his life with somatic reactions, and has been making a systematic and intensive study of them during his preclinical period, whereas his introduction to the infinitely more complicated study of the psyche has only just taken place, and consists of a few lectures on elementary medical psychology. If he were to embark on his clinical period with a knowledge of the physiology of the mind in any way comparable to his knowledge of the physiology of the body, the difficulty mentioned above and many others would not exist.

To begin at the very beginning, the student should know that it is impossible to be aware of anything without experiencing some degree of feeling about it, and that one cannot *feel* about a thing without to some extent wanting to *do* something about it. He should also know that emotion is always accompanied by bodily changes and can only express itself by means of them. Needless to say, he should also know —as far as any of us know—*why* these things are so.

During his course of instruction in physiology very special attention should be paid to those remarkable links between the physical and the psychological, the endocrine glands, and some special lectures by a suitable person should be given on the psychological aspect of the matter. The same is true in relation to the physiology of all the special senses, of digestion and very particularly of reproduction. The student, in fact, should have been trained to consider all bodily processes from their psychological as well as from their material or mechanical aspect before he ever sees a patient.

Such training, however, is not assumed in this book, and while the student is acquiring it the following exposition of the difficulty of fully understanding the language of symptoms may possibly be of some interest and help to him.

Most of us would say, if asked, that the best way to convey important information is to phrase it in something approximating to the King's English and present it clearly spoken or legibly written to the recipient in a way that " any reasoning being should understand." That is not the method adopted by the psyche. The psyche is uneducated and uneducable in the conventional sense, and it is only the conscious mind—a very small and unimportant part of it, medically speaking—which is able or willing to adopt the painfully formal and time-consuming method referred to. For that matter we all rely as little as possible upon the method in the conduct of everyday life, though it is, of course, an ideal one for recording the resolutions of a strong committee or conducting the intercourse of two great and friendly nations.

Psychosomatic unity was a fact long before modern research rediscovered it, and long before the conscious mind was sufficiently educated to assume dictatorship over the human organism and obtain widespread recognition of its claim. The

true psyche has never really recognised the claim, however. Continuing its age-old alliance with soma it sticks to its ancient language of symbol and imagery, using the somatic machinery for the purpose. Our attempts to ignore or check this procedure are, at the best, half-hearted. We accept the idea of "one reasoning being communicating with another," largely because the mechanism of speech has been taken over practically entire by the conscious mind, except in that open rebellion of the psyche which is delirium; but far more constantly than we realise we all tend to circumvent our tyrannous "educated" conscious minds and their methods and to fall back on that sign language which is the oldest language of all. Far from being obscure, that language is universally understandable if we would but realise the fact. We all use it precisely when we wish to express ourselves most clearly and forcibly, and the enormous part it plays in our lives is well illustrated by the fact that every part and organ of the body is constantly referred to in a figurative sense in our daily conversation. The number of ideas which we express best and most vividly only when we put them in terms of body is truly astonishing.

A broken-hearted man is not suffering from cardiac disease nor yet from a fracture of any description. The conditions colloquially termed "a pain in the neck" or "one's nose put out of joint" do not call for physio-therapy or surgery. People who make you "sick," or "tired," or "speechless" have not really done you any bodily harm; certainly not enough to bring themselves within reach of the strong arm of the law. The cold hand of death will not be laid upon you just yet, and in spite of your speechlessness you will have no difficulty in expressing yourself by means of your threatening glance, your forbidding frown, your angry stride and your defiant gestures. The soothing touch of time may bring ability to digest the whole matter, to stomach insults received and to swallow excuses offered. You will doubtless express your altered state of mind in "nods and becks and wreathed smiles," and you may even go the length of indulging in an amiable grin and a knowing wink, despite the raised eyebrows of your friends.

The figurative references in the above to bodily organs and

processes convey vividly and in a word ideas which otherwise could only be expressed by flat and clumsy periphrasis, while the actual contortions and grimaces mentioned have been accepted by mankind from time immemorial as a kind of universal psychological shorthand of unique speed and accuracy.

Now let us go just a little further and apply all this to the well-known case of the schoolboy " creeping like snail, unwillingly to school." He creeps like snail because he has got to go to school and doesn't want to. His solution of that difficulty is to prolong his journey at the risk of making things worse for himself by arriving late. It is certainly just the sort of solution one might expect from a child. But before discussing what else he might have done, let us consider this question of creeping.

The boy looks the picture of health (he has, you remember, a " shining morning face ") and I think that most of us would diagnose his condition without difficulty as a very simple childish reaction and leave it at that, pointing out that the boy was inexperienced and as yet uneducated.

Well, let us grant the boy some more education. Education has been defined—very aptly for our present purpose—as the training of people to do what they ought to do when they ought to do it, whether they want to do it or not, so if our schoolboy were completely educated the creeping trouble would be eliminated once for all. But he is by no means fully educated. Like most of us he has only got to the stage at which he strains every nerve to appear as well educated as his fellows. He has learned—probably by painful experience—what things are " done " and " not done " in his set and he does his utmost to avoid their displeasure and gain their favour by strictly adhering to their codes and standards.

Now let us say that one of the things which are " not done " by his little group of friends is to show dislike or fear of attending school. This is unfortunate for him, because his feelings on the subject have not altered since his creeping days. Even then he was a little ashamed to mention his creeping and the real reason for it, and now he would not dream of uttering a word about it to save his life. He has, in fact, gone to the very opposite extreme and has professed his enjoyment of school so

often and so enthusiastically that at times he almost believes his own statements. But the basic feeling remains unchanged, and the situation has now become too complicated to be saved by an occasional spot of creeping, be it never so snail-like. He cannot overcome his abhorrence of school, he dare not now admit it, and he will not adopt any obvious childish manoeuvre which would be seen through by his companions *and by himself*, with loss of popularity and of his own self-respect as its immediate consequence.

There is only one solution. He redoubles his protestations of complete happiness, convinces himself of their sincerity and makes a tacit bargain with the uneducated and uneducable part of his mind. He is to be relieved of all doubts or misgivings as to his happiness at school and his desire to attend it, and he will, in addition, be presented with a real live symptom which will give him a cast-iron excuse and justification for not attending it. For his part, he must accept with indifference and, if possible, with cheerfulness, any discomfort or disability in which the symptom may involve him while fulfilling its main object.

The foregoing is an outline of the origin of " the unconscious motive." It need hardly be said that the picture is a greatly simplified one and that many stages, modifications and variations of it have been omitted.

It is specially to be noted that the last case of our schoolboy is infinitely worse than his first. He has yielded up much of his insight into, and therefore his control over, the situation, and his dislike of school will now be expressed not by a conscious and transparent childish device, but by a symptom as inexplicable and effective as it can be made by a part of his psyche which has that object, and only that object in view. But though this little excursion into psychopathology has been unavoidable, our main business is with our young friend's symptoms rather than with theories as to their mode of origin. Let us take a final look at him. Something serious seems to have happened to him since we saw him last. He is confined to bed, for the good reason that he has lost all power in the muscles of both legs, and is clearly suffering from what is called a flaccid paraplegia. He pled so earnestly to go to school today, as an important examination is being held, that

an attempt was made to get him up and dressed, but it ended in disaster. He collapsed on the floor and had to be lifted back to bed. It was then discovered that in addition to the loss of power there was a complete loss of sensation in both legs from the knee downwards. The doctor has just arrived and has followed the excellent old practice of reviewing in his mind all the conceivable diagnoses of the case before deciding on any one of them. He concludes—quite correctly—that there are three possibilities, namely (1) conscious malingering, (2) some one of several "organic" conditions (*i.e.* injury, infection or disease of some part of the central nervous system), (3) "functional" nervous disease. We are not yet in a position to discuss the details of the procedures he adopts to help him to his final diagnosis. We may say confidently, however, that he is very likely to start with a considerable bias in favour of group 2 for the reason, among many others, that the methods and instruments with which he is familiar are applicable to group 2 almost exclusively, and yield little or no information about disorders not in that group. In this case, however, he will find that his examination yields contradictory and bewildering results which seem to lead nowhere. The danger now is that rather than look at the symptom-group as a whole, in which case the true diagnosis would present itself to him instantly, he will order further investigations, lumbar-punctures, second opinions, special tests, and so on, because he can only see what he has been trained to see, and is using the only methods he has been taught. When he reluctantly decides that a case is not amenable to these methods he is sadly apt to lose any further interest in its accurate diagnosis or its proper treatment. Nobody expects him to be a specialist, and nobody denies that a careful and thorough examination of a patient is always right and necessary. The point is simply that he should have been taught as a student that no full understanding of a symptom group is possible without an assessment of the patient as a human personality with a certain history, in a certain domestic, economic and psychological situation. A symptom-group apart from that background is never fully intelligible and very often meaningless or misleading. Combine both parts of the picture every time you deal with a patient and you will find that, viewed thus, symptoms have a wealth of meaning and

message and that you are well on the way to learning their language.

After a very short while you will find that, far from losing time, you are saving it by this procedure, as the doctor would have done had he adopted it in our imaginary case. That case, by the way, was not so very imaginary after all. While writing about it I had in mind a patient who spent three years in bed, suffering from a flaccid paraplegia, the true nature and proper treatment of which had somehow been overlooked. Lest you should be told that " they always recur," I had better mention that this particular patient has remained well for fifteen years.

In present circumstances the best place to learn the language of symptoms is the out-patient department of any big hospital, though of course the difficulty of time and numbers is very real. Some years ago one very " advanced " hospital arranged a series of combined teaching rounds in one of its medical wards by the physician in charge of it and the physician for psychological medicine. These colleagues expounded the complementary aspects of the various cases to the students. I do not know why the experiment was discontinued.

But the out-patient department provides abundant opportunity for looking at every patient as a human problem as well as a medical one, and for observing the tragic results which are apt to follow when this is neglected. Please note that it is not a question of actual blunders in diagnosis or treatment ; very far from it. If it were merely that, there is no doubt that the department of psychological medicine is as great an offender as any, and greater than most. It is a question of an *incomplete* view of a case leading to a distorted picture of the symptoms and thus to a faulty interpretation of their language. Treatment, in consequence, though admirably sound as far as it goes, is apt to be just a little inadequate in the sense that the essential ingredient of psychological understanding and help is occasionally minimised. It is needless to go further into the matter especially as this book is not directly concerned with treatment at all. The student who has the eyes to see, however, will surely realise as he makes his way through the various special departments, how completely psychological medicine pervades, or should pervade, them all, and what incalculable

benefit will accrue to patients, teachers and taught, as the essential unity of psychological medicine and "general" medicine becomes fully and practically recognised.

In this and the preceding chapters the supreme importance of psychological insight has been repeatedly emphasised. It would be absurd to imagine that a weapon of such potency could be obtained for the asking, or used effectively without much training. The matter is further complicated by the fact that the difficulties in teaching medical psychology are formidable from the very beginning. The beginner on the piano who can perform simple pieces to the general satisfaction without having ever heard of Beethoven is in much happier case than the student—or the teacher—of elementary medical psychology in which a profoundly difficult and debatable mass of theory is constantly obtruding itself.

Some technical background, however, is essential from the earliest stage, and the next few chapters are an attempt to present this to the junior student in a form which will suffice for his immediate needs and will at the same time maintain his interest in the practical applications of the subject.

Chapter 4

THE UNCONSCIOUS MIND

This book is a supplement to, and not a substitute for, the lectures on elementary medical psychology which the student will receive as his first introduction to the subject. It is mainly concerned with certain practical aspects and applications of medical psychology which, in the writer's opinion, are rarely given sufficient prominence in any course of lectures, elementary or advanced. In such a book theoretical discussion should clearly be reduced to a minimum, and should not go beyond outlining basic principles and defining essential terms. Unfortunately it is extremely difficult to present the fundamentals of medical psychology briefly, clearly and impartially to those who have no previous acquaintance with the subject, or even to decide what the fundamentals are.

The study of medical psychology, unlike that of, say, the English language or mathematics, is based upon theories and principles which are much more complex than the alphabet or the ten digits, and yet some grasp of them must be obtained from the outset. Elementary teaching will otherwise fail to provide a sure foundation for more advanced study, will be incomprehensible in itself and will prove to be much worse than useless. Psychology permeating all medicine as it does, the above applies not only to the specialist in embryo but also, and perhaps especially, to the student who has no intention of pursuing the subject after graduation. The failures of the following attempt to tell beginners as much as is necessary and no more of the theory on which practice is based must be corrected in both directions—as must those of all written teaching—by the lecturer.

In the foregoing chapters we have been speaking of " maladjustment," and it is clear that we cannot properly discuss its effects on conduct and health until we have tried to discover and set forth in reasonably clear and scientific language what maladjustment really is and how it is brought about.

There are many answers to that question and the first thing

to note is that they are all theories or, rather, working hypotheses. They are very useful ones in their way, but the student must realise from the outset that they have nothing whatever in common with scientific fact or " natural law." They are quite incapable of logical proof, nor can constant observation and experiment provide unvarying confirmation of them. They are as near to " airy nothing " as the square root of minus one, and to give them " a local habitation and a name " in the student's memory the teacher has no choice but to use analogy and illustration with all the crispness and vividness at his command.

The student, familiar with theories which he can verify in the laboratory and processes whose effects he can see in the post mortem room, should remember that psychological theories are matters of a very different order, however precise and dogmatic may be the guise in which they are presented to him " for teaching purposes."

The next important point is that none of these working hypotheses is complete and all of them leave many questions not only unanswered but unanswerable. This reminder is specially necessary because there are three or four outstanding systems or schools of psychology which in due course it may be your business to study in some detail. Any short, summary teaching about these is almost bound to present them to you as a few complete, independent and mutually opposed systems, each with its own special slogans and catchwords. In consequence you tend to associate yourself with one special school, stressing its differences from and apparent incompatibility with the others, and overlooking the fact that they are all simply different aspects of and lines of approach to one great whole which no single system can apprehend fully or describe adequately.

Some years ago a candidate replied to one of my questions at an oral examination with the words : " Ah, I see that you are a Freudian ; now, I'm a supporter of Adler ! " I had to remind him that we were not discussing the merits of rival football teams.

The attempt to discover to what extent the real essentials of the various schools of psychology are merely different ways of saying the same thing is a task which the junior medical student

would be most ill-advised to undertake. In the time gained by refraining from it he might very profitably study the old Eastern story called " The Disagreement as to the Description and Shape of the Elephant," as set forth in the opening pages of Kenneth Walker's remarkable book *The Diagnosis of Man*. Let him at least shun the fatal error of regarding one school of Psychology as the " right " one, and all the rest as " wrong " ones. The palace of Truth, like the New Jerusalem in St. John's vision, is four-square with gates in each side, which means that people may reach it from opposite points of the compass, unlike the " workers on parallel lines " who appear doomed never to meet at all.

No attempt is made in this book to conform to the tenets or the terminology of any one school of psychology. Explanations are phrased and illustrations chosen with the one object of helping the student to understand the practical applicability of psychological principles to general medicine and to observe and appreciate their working in everyday life and conduct. He need therefore feel no alarm or elation should he discover that some description or application does not appear to be quite consistent with a previous or subsequent one.

It is only fair, however, to say that as far as its basic principles are concerned modern medical psychology owes infinitely more to Freud than to anyone else, and it is impossible to give even the simplest definitions, whatever one's viewpoint, without abundant borrowing of his conceptions and his very phrases.

From this long but necessary digression let us return to the question : How do people come to be maladjusted to life ? They come to be maladjusted because in some respect or other they are unable to face its realities and adapt themselves to its demands. And why are they so ? Because they are unable to devote themselves to the business with unity of purpose. And why not ? Because their minds are not homogeneous. They are a confused mass of conflicting and incompatible motives and desires, and the unfortunate possessor of such a mind spends most of his nervous energy in superintending the conflicts. Why does he not make up his mind for better or worse, one way or other, and be done with it ? Because his mind is actually a house divided against itself. It is itself the source—the inexhaustible source—of the opposing motives and

mutually inconsistent desires. Further, the individual is not aware of the nature, or even of the existence, of many of these motives and desires. He only knows that whenever he attempts to act whole-heartedly in any one direction he is vaguely aware of some compelling force which forbids him, or pulls him in the other. "And thus the native hue of resolution is sicklied o'er with the pale cast of thought." He simply does not know what he wants to do. He cannot make up his own mind for the good reason that he, very literally, does not know it. "A double-minded man is unstable in all his ways."

Consideration of the nature of this mental disharmony and self-ignorance leads us straight to the fundamental conception of "the unconscious mind." It is amusing and a little pathetic to recall the rage and fury, the spilling of ink and the "throwing about of brains" which the mere mention of this subject used to arouse not so very long ago. It is now almost universally accepted as an essential and invaluable working hypothesis and it will not be necessary here to enter into the evidence in favour of its existence or to discuss its origin at any length, though these are very suitable topics for a lecture course. It is a conception of such value and a starting-point of such vital importance that it merits careful description and close attention, but all that is necessary for our present purpose can be said at no intolerable length and without fear of raising the ghosts of forgotten controversies.

Consciousness at any given moment includes everything of which we are aware at that moment, and nothing more. We may, for example, be aware of tactile, visual and auditory sensations, aware in a more vague way, of a blend of various organic sensations and aware of some idea which is occupying our attention. This is our "field of consciousness" for the moment and of course it varies from instant to instant, as it depends upon the sensations and ideas of each moment and the manner in which we are distributing our attention among them. The more concentrated our attention is, the smaller will our field of consciousness be—a fact which enables people whose attention is sufficiently concentrated upon some study or purpose to pursue it in most unfavourable circumstances and become, to use the popular phrase, "oblivious of their surroundings." Many an injury received in the heat of battle

or even in the excitement of a game of Rugby football is completely ignored by the victim, who does not even realise that he has been hurt until he has " time to think about it." On the other hand, as we are all painfully aware, it is only too easy for us to " allow our attention to wander " and to spread itself thinly, as it were, over the multitude of stimuli which are constantly competing for a place in our field of consciousness.

Everything " in our minds " of which we are not at the moment aware is said to be in " the unconscious," and this unconscious mind is conceived as consisting of a superficial division or layer called the foreconscious and a deeper one called the true unconscious. They must be considered and described separately at first.

The foreconscious (often popularly called the subconscious) contains all the material which we can ourselves bring into consciousness by our own unaided effort—though the nature of the effort will require some explanation. Telephone numbers, addresses, " dates " both past and future, items of general—and sometimes of medical—knowledge and so forth, are examples of this material.

The foreconscious can manipulate the material it contains, often in remarkably complex fashion, as can be demonstrated very strikingly by the elaborate mathematical calculations which a hypnotised subject can be made to perform.

It is such activity as this which has been held to justify the title of the unconscious " mind." It is common knowledge that subconscious activity persists during sleep, and there is many a problem regarding which : " Sleep on it " is much wiser advice than : " Keep thinking it over." In the same way, we all know that when we cannot remember, say, a name which we " really know perfectly well " and is " on the tip of our tongue," our best course by far is to cease all effort to recall it. The foreconscious will not produce the name " on demand," but if we leave it to work in its own way without interference, and turn our conscious thought completely away from the matter, we shall more often than not be rewarded by the reappearance of the name in our consciousness with dramatic unexpectedness and an almost audible " click."

The reappearance is due to the extremely interesting and

important psychological process called the association of ideas, into which we cannot go fully at present. We must note, however, that it is the normal route for traffic from unconscious to conscious and is undoubtedly " the shortest road there," however much it may seem to be " the longest way round." Conscious effort to control the traffic obstructs the road instead of clearing it, but in this matter, as in many others, we are slow to learn that we can help most by interfering least. As we shall shortly see, consciousness is often by no means sorry to have the road from the unconscious blocked, and her seemingly well-meant efforts, like those of the interfering person who " only wants to help," are often something a good deal more than an honest mistake.

The " true " unconscious, or " the unconscious," as we shall now call it, contains material which cannot be brought into consciousness without the help of technical psychological procedures. This material consists of two classes, namely, matter whose acquaintance consciousness has no desire ever to make, and matter which consciousness never wishes to meet again.

It is assumed that apart from the thinking, feeling, educable mental apparatus we possess (undeveloped, of course, at birth), we start life with a much simpler, cruder, infantile " primary mental system " which, like the instincts of which it is largely composed, is uneducated and uneducable. It is therefore entirely non-moral and egocentric, and is altogether concerned with seeking satisfaction and avoiding pain—that is to say, with gratifying desire. Its way of accomplishing this can only be purely sensory. As it is quite unfettered by reality and has no relation or power of adjustment to the facts and circumstances of outside life, an imaginary picture of fulfilled desire is the only attempt at gratification of which it is capable. There is, for example, strong evidence that a hungry infant's first attempt to obtain satisfaction of its need is by producing a mental picture of the mother or nurse whose last arrival meant a feed, or perhaps by reviving the sensations produced by breast or bottle. In precisely the same way Arctic explorers, prisoners of war and others return to this infantile method by composing menus of the elaborate dinners they will order and consume " some day." They do this not from utter ignorance

of painful reality, but as an attempt to escape for a moment from a reality they cannot alter.

A very short experience of the transitory and unsubstantial nature of imaginary gratification brings the infant's " secondary " educable system into play in rudimentary fashion, and he learns in due course his very first lesson which is that the tiresome process of lusty crying will bring him a less immediate but much more real and solid satisfaction. He is much pleased with the success of his attempt to alter the environment, regards his crying as the magical means of obtaining his desires and resorts to it for that purpose on every possible occasion, having " no language but a cry." But the " secondary " system grows, learns and develops in close contact with reality every day. It steadily supersedes and supplants the primary one, and in a very few years the child of our example wastes no time, when hungry, in " the bare imagination of a feast," but sets out to obtain real satisfaction by the comparatively roundabout method of procuring money, entering a restaurant, ordering food and eating it. His secondary system is now in charge, and its activities are directed not inwards for the purpose of producing an unreal impression of gratification, but outwards for the purpose of so altering the environment that a real and permanent gratification will result.

The primary system remains quite distinct from the secondary one, and persists throughout life, not greatly altered, as the unconscious mind. We all tend to fall back upon its methods when faced with insuperable difficulty or intolerable reality, and some of us do so on much less provocation than that. Traces of its activities and indications of its methods can be observed easily enough in some neurotic symptoms, in some of the acute insanities, in the day-dreams and phantasies of the normal adult, in the conduct of very young children, and, most clearly and unmistakably of all, in dreams. All these are suitable and indeed essential subjects for a student's further studies and teaching in psychological medicine.

We must now consider the relation of the unconscious mind to consciousness, postponing for the moment a discussion of what we have called its " contents." It is obvious that as the unconscious can only make pictures of fulfilled desire it cannot of itself bring its desires to fulfilment in a world of reality with

which it has no direct contact whatever. The normal procedure is for the unconscious to invite, or rather incite, the conscious mind to carry out the desire to real fulfilment, at the same time providing and handing on, so to speak, the energy and driving force necessary for the purpose. This " passed to you, please " system works quite well as a rule, though subject to the irritating delays that seem inseparable from any such system. But speed is not everything. If you care to fall back on the methods of the unconscious, you can pass your qualifying examination and any others that take your fancy in very much less time than you require to master the anatomy of the sphenoid bone. But the moment you " come back to earth " from your dream, or day-dream, or attack of insanity, you find yourself bereft of your magically gained degrees and honours, with the sphenoid bone and one or two other things still to learn, and some years in which to do it. On the other hand, a qualification achieved by the laborious old method will be a real one and you will hold it all your life, provided you behave yourself.

But there is a complicating and upsetting factor which brings us to the root of the whole matter. The conscious mind, as we are all proudly aware, is full of wise purpose and foresight. It is capable of reaching towards ideals, it can be educated up to altruism and, in general, it can take the long view and put up with present inconvenience and pain for the sake of more permanent future benefit. The " passed to you " memos it receives come from the illogical, irresponsible, non-moral, unconscious mind which, in its glorious detachment from reality, works only on the " bird in the hand " principle and seeks nothing but immediate gratification of desire without thought of consequences. What do you imagine the nature of its messages is likely to be, and how is consciousness likely to react to them?

Before dealing with these questions a very short digression is unfortunately necessary. The student may or may not have been taught as yet anything about instinct, but to understand what follows it is essential that he be told, or reminded, of one or two isolated and elementary facts. An instinct is an inherent prompting to act without deliberation in a certain way. When we become aware of this prompting we experience an

emotion of comparable strength to the prompting and closely related to it. When the first man became aware of the first tiger he felt afraid *and* ran away. If he was very much afraid he ran very fast and far. These aspects of an instinctive act have technical names. " I knew thee, that thou art an hard man " (Cognition), " and I was afraid " (Affect), "and went and hid thy talent in the earth " (Conation). The conative energy accompanying an instinct is almost inexhaustible. The desires which the unconscious sends up to the conscious to be worked out in life are associated with our strongest instincts, and this explains the affect and the energy which go along with them.

To return now to the questions just asked, it is clear that many of the ideas passed up by the unconscious " for necessary action " cannot fail to be most unacceptable to a conscious self which has been educated up to respect for logic, morals, altruism and criminal law. We must note, too, that the problem before consciousness is not merely how to deal with the obnoxious idea which has been presented to it, but how to dispose of the emotional force, and the urge to action which accompany the idea in abundant measure. As we shall see, it will not suffice therefore for consciousness merely to reject the idea as unsuitable or unwise, and leave it at that. Some method must be found of dealing with its associated energy. The usual procedure in ordinary mental health is that consciousness admits and accepts the idea which, after all, is " one of the family," having come, not from outside, but from the depths of the mind of which consciousness is the top layer. It then trims and modifies the idea, licking it into a shape which will conform to conscious standards, and gets on with the task of working it out. If its new shape does not provide adequate outlet for its accompanying energy, the surplus is switched almost automatically into any available " side-tracks "—ideas and activities which are essentially allied to and representative of the original one, but which are socially desirable or at least harmless. This process is known as Sublimation and it has been the subject of a good deal of theoretical discussion which we may avoid with advantage. As a matter of practical fact, sublimation as just outlined is a normal, healthful and necessary process in mental life. It is, for example, by means of sublima-

tion that we absorb the energy which in its crude form points towards abduction and rape, in such comparatively harmless pursuits as dances, cocktail parties, two seats at the theatre, an afternoon on the river, discussions on art (or psychology), the reading of good poetry, the writing of bad poetry, feats of derring-do on the football field or elsewhere, and an unwonted benevolence to mankind in general.

Sublimation in its proper sense is not a process of conscious decision that a " side-track " is required, followed by conscious selection of one. Such processes, of course, occur in the lives of all thoughtful and sensible persons, but the energy of which we are speaking will not be forced into any channel which consciousness may happen to approve. It will choose its own outlets, and consciousness can really do little more than see to it that there is a good selection to choose from. The importance of that point in psychological medicine and particularly in the treatment of children and adolescents, cannot be overstressed. An advanced study of sublimation throws light in most interesting fashion upon the boundless enthusiasm and devotion with which certain persons associate themselves with some special cause or activity, and often upon the reasons why some particular career was ever chosen.

We must return, however, to consider the point that all sublimation implies some degree of modification by consciousness of the desires and demands arising from the unconscious, and that this process has its limits. The limit is reached when consciousness finds these demands so objectionable that it refuses, point blank, to admit them for inspection and possible modification. Sublimation's policy of " appeasement " is thus brought to a standstill. But consciousness goes further yet. Not only does it refuse to have anything to do with the obnoxious idea, but it denies its very existence and proceeds to set up a barrier which will prevent it from ever gaining admittance to the thinking, working, conscious mind which alone is capable of providing an outlet for its energy and bringing it to satisfactory expression and fulfilment. The name of this barrier is " Repression."

Few words are so misused and misunderstood, and none is so important in elementary medical psychology, as this one. Repression is not a conscious and voluntary act, and has

nothing to do with conscious restraint and control. Any conscious effort to " repress " an idea necessarily involves an awareness of what is to be " repressed," and this is exactly what the individual does not possess. It is quite true that this statement seems inconsistent with what has already been said and with some of the illustrations and analogies shortly to be given. The student must remember, however, that we are dealing from start to finish with abstract theories. The pictures and symbols which we are forced to use to present them in anything approaching concrete logical form can only deal with a few of their numberless aspects and are bound to be incomplete in themselves and sometimes apparently inconsistent with each other. The student can only be again asked to believe for the present that they are merely different ways of saying the same thing. In particular, he may find it difficult to form a clear picture of the relationship between sublimation and repression, and to decide at what point " normal " reactions cease and " abnormal " ones begin. Let him remember, however, that the relations between conscious and unconscious do not conform to any rigid schedule. There is a difference between a psychological theory and the blue-print of a piece of machinery.

Repression, then, is a barrier between conscious and unconscious, beyond which the " desires " of the latter may not pass unless they assume a form which, while giving them adequate expression, is also acceptable to the codes, morals and sentiments to which the former has been educated. If this should occur, sublimation can resume its good work, and all will be well ; but if not, what is to happen to the bottled-up energies which have been denied all possible outlet ?

Let us suppose you are the chairman of, say, a political meeting and that as you take your seat you observe at the back of the hall a group of young men who appear likely to cause trouble. If you are a wise chairman you will take an early opportunity of inviting them to take a share in the meeting. You will indicate tactfully that they are only a part of the meeting, but you will stress your wish to give all sides a fair hearing, and you will invite their spokesman to express their point of view. This procedure will go far towards taking

the wind out of their sails and may possibly even turn them into courteous and interested listeners for the rest of the meeting. At the worst you will have robbed them of any ground for complaining that they were not given an opportunity to air their views.

On the other hand, if you are a weak or timid chairman you may summon your stewards and, murmuring something about prevention being better than cure, give orders for the summary ejection of the potential disturbers of the peace as the first item on the programme. After this has been quietly accomplished the meeting will proceed with a suspiciously unruffled placidity until, perhaps, you reach the peroration of your patriotic address. At this point a raucous voice "off" will be heard to assail your character, cast doubts on your parentage, or indicate your ultimate destination, and a dead cat or half a brick hurtling from the outer darkness through the window on to your desk will emphasise the spoken words.

The words and the missiles are the contribution made to the proceedings by the people whom you prevented from expressing their views in more conventional fashion. They have climbed up some other way like thieves and robbers and have expressed themselves in the only fashion open to them. You need not, therefore, be surprised that their contributions are more illogical, more bizarre, more intrusive and more difficult to deal with than, say, a question or a point of order arising in the course of the meeting.

The meeting, I need hardly explain, is your conscious mind. The young men are tendencies, desires, memories, instincts, hopes, fears—parts or aspects of yourself—which your educated conscious mind refuses to accept and acknowledge. The dead cat and half brick are anything from minor disorders of conduct to gross neurotic symptoms—the expression of material that must express itself somehow, and that has been denied any more normal or direct method of doing so. It is this necessity for roundabout forms of expression which explains the irregular and, as it were, unexpected nature of many nervous symptoms, and their apparent detachment from and inconsistency with the main stream of life and thought upon which they intrude.

Now, faced with this variety of gate-crashing, what is the poor chairman to do? There are only two things he *can* do. On the one hand, he can divide his attention between his speech and the bricks, attempting to continue the one while he copes with the other. This method has the drawback that as the speech is interminable and the flow of missiles inexhaustible there is no prospect of either activity ever coming to an end. Like all people who try to do two things at once he will fail to make a satisfactory job of either. He may certainly acquire great dexterity in avoiding injury from the bricks, and may in time become able to catch them adroitly and pile them in neat patterns while keeping up a ceaseless flow of oratory, but jugglery of this kind, while it will undoubtedly "set on a quantity of barren spectators to laugh, cannot but cause the judicious to grieve." His one consolation, for what it is worth, is that this method of dealing with the situation is strongly recommended by a majority of the medical profession.

Alternatively, he can put two and two together and infer that the throwers of the bricks are the people to whom he refused a hearing. He can then admit his error frankly, invite them to return, and listen to what they have to say. This will probably be a humiliating experience, but it will have instantly beneficial results. The stream of interruptions from outside will, of course, cease at once, having been, so to speak, cut off at its source. He will learn, for the first time, what the disaffected persons have to say and will know just what he is up against. He has also the comforting knowledge that there is a strong majority in the room on the side of the angels who will support him as long as he gives fair play to all.

It is not easy or pleasant for anyone who has refused to admit the very existence of some of the grimmer aspects of himself to watch them rise up to condemn him, one by one. "I had no idea," he says, "that I was so idle as that, so cruel as that, so lustful as that, so cowardly as that," and so on. "But I am thankful," he may well add, "that I have some idea now, because now, for the first time, I shall be in a position to control and restrain and guide these parts of myself, and to direct their activities into desirable channels. This has

hitherto been impossible because I had no idea of the true nature and strength of the forces with which I was trying to deal."

Self-knowledge, in fact, is the first essential preliminary of self-guidance and self-control. It is the foundation of all true psychological stability, and to attempt to build up complete and consistent character without it is like attempting to build up a jig-saw puzzle when a dozen of the pieces are lying lost under the mat.

Chapter 5

"MENTAL MECHANISMS"

We have seen that the great function of repression is to prevent certain material from ever reaching consciousness. Whether repression can be removed altogether, with the presumable result of one-hundred-per-cent. self-knowledge, is an abstruse theoretical question of the greatest difficulty which, most fortunately, does not concern us. In all probability such a thing is impossible, and to judge from the results of such attempts as have been made it would certainly be most highly undesirable. When one gets to the depths of the unconscious, self-knowledge is one of the good things of which it is possible to have too much.

Repression, however, has another function which, though more superficial and less important psychologically than its main one, is more readily explained, is more easily demonstrated, and has a very close practical relation to daily life and to general medicine. This function is to remove from consciousness the memory of painful experiences, unpleasing ideas and the like, and enormously to increase the difficulty of recalling them. This material forms the second group of the two into which, you will remember, we divided the contents of the unconscious—material which consciousness "never wishes to meet again." It is very doubtful whether material repressed in this way ever sinks really deeply into the true unconscious, nor need it matter to us. We can now safely regard the whole thing, including the demarcation between foreconscious and true unconscious as simply a question of degree.

Repression carries out this second function by attacking the "association of ideas" by means of which, as has been said, contact is maintained between conscious and unconscious. It deals with an irritating group of ideas by cutting off its associative links with the other matters in consciousness and enveloping it, as it were, much as the omentum deals with a foreign body in the abdominal cavity. The completeness of

this process, and the depth to which it causes the irritating material to sink into the unconscious are extremely variable.

All material in the unconscious, whatever its length of residence, method of arrival and depth of penetration, is to be considered as striving to pass the barrier of repression and gain—or regain—admission to consciousness where alone it can express itself adequately. There are occasions, which do not now concern us, on which it succeeds in bursting clean through the barrier—usually with devastating psychological results. But as a rule the repressed material attempts to dodge or circumvent the repressing force and appears in consciousness by some roundabout route and so disguised that it will not be recognised—by the individual concerned, at least—for what it is. The illustration at the close of the last chapter makes this point clear. The struggle between repressed material and repressing force is called " intra-psychic conflict " and is the state of things referred to earlier in that chapter when it was pointed out that no man whose mind is a house divided against itself can hope to succeed in adjusting himself to life, because he cannot bring singleness of purpose to the task.

He can only achieve that singleness of purpose when repression is prepared, not for unconditional surrender, but rather for voluntary liquidation, and all the facts of the case without distortion or reserve thus come under conscious direction and control. Their need for abnormal and roundabout expression will obviously cease at once, and the individual will have advanced one step nearer to becoming what Arnold Bennett called " Lord over the noddle," and Henley " Captain of his soul."

The various manoeuvres by both sides in the intra-psychic conflict between repressed material and repressing force have been given the rather unfortunate name of " mental mechanisms." As has been emphasised, the whole matter is the very reverse of mechanical, but the name can at least claim some justification from the fact that all intra-psychic conflicts tend, in their general outline to follow one or more of quite a small number of familiar and pretty well defined patterns, though in detail each is a law unto itself. These mechanisms are at the root of almost every aspect of our mental life, they explain and elucidate the symptomatology of nervous and

mental disorder, and they are abundantly illustrated by our conduct in daily life, which they influence to a remarkable extent.

It is with their application to everyday life and work that this book is concerned, and a detailed study of them would lead us much further into medical psychology than it is our present object to go. I purpose, therefore, to give here only the barest minimum of general description and theory, and a maximum of analogy, illustration and practical application.

The first of them—Dissociation—is really synonymous with the very simplest and most superficial forms of repression. It is simply the production in the mind of a number of " logic-tight " compartments, as they have been well called, each of them shut off from association with the others, and containing its own little group of ideas. We cannot call the groups " repressed " in any true sense, because consciousness has no particular objection to any one of them by itself—quite the reverse, in fact. The trouble is that they are so painfully inconsistent with each other that consciousness cannot entertain them together. Hence they are isolated rather than banished, they live in the very topmost layers of the fore-conscious and the function of dissociation is simply to take care that any two of them who do not get on well together do not both call on consciousness at the same time, and that neither mentions the other when in her presence. If we call one of them " Principle " and the other " Practice " the convenience of this arrangement will be obvious to all.

The mechanism of dissociation can, of course, function in a far more important and massive way than this. It is, for example, at the root of such profound psychological disturbances as fugues and double personalities. The term is also used in psychology to explain such remarkable phenomena as the ability of many an unassuming old lady to knit, read, and listen to the radio at one and the same time. But its activities, like those of repression, can be seen in the most trivial details of life and conduct, and it is with this aspect of it that we are now concerned. It is said with much truth that our most trifling lapses of memory, slips of the pen or tongue, " absent-minded " actions, inconsistencies of conduct and so forth, can be demonstrated to be due to the activities of

repression and dissociation, and the efforts of repressed or disassociated material to elude the former or break free from the latter.

I am writing these words on the last day of a holiday and should much prefer to be spending the day on the golf course where I played my last round yesterday, and brought home my clubs. I have just discovered, however, that most unfortunately, I have " forgotten " to bring back some valuables from the club house, and shall have to call for them this afternoon. And since I *have* to go there . . . etc.

Several years ago my secretary, Miss A., spent much time and energy in telling me of her dislike for my assistant Dr. B. At a party one evening she was told of the very regular habits, simple tastes and exemplary morals of my friend Dr. C., a married man, whereupon she remarked, with merry girlish laughter : " Oh, what a happy woman *Mrs. B.*—I mean Mrs. C.—must be ! " She became engaged to Dr. B. a fortnight later.

Many years ago, within twenty-four hours of a social function at which my attendance was essential, the details of which had occupied me for weeks, I made two private appointments for the very hours at which the function would be at its height. To attend the function was an intensely disagreeable prospect to me. Dissociation gave temporary relief by shutting off the whole matter from its normal relation to my conscious mind, isolating it, as it were, like a globule of oil in a badly made emulsion. Repression helped by seeing to it that the globule did not put in an appearance at the wrong time. It did this so effectively that even the actual mention of the significant hours was not used as an associative link. It may be thought that this would have been the " right " time and not the " wrong " one for the matter to have reappeared in consciousness, as it would have prevented me from making appointments which I could not possibly keep. But the complete difference of method and aim between conscious and unconscious, which has already been explained, must always be remembered. The latter has nothing to do with rights, wrong, duties, obligations, possibilities or results, and it is only to be expected that in most cases, as in this one, the activities of repression, dissociation, and other " mechanisms " yet to be studied make

things worse rather than better from the conscious " long-term " viewpoint.

In the instance just given the whole process was a frail and superficial one. It could not, for example, have withstood a visit to my office that evening, where a glance at my desk would have restored the homogeneity of my mind in the matter. As it happened, I did not return to my office that night and it is of interest and significance, though we shall not pursue the point, that the dissociation held until I awoke in the small hours of the morning with a sudden awareness of my " mistake."

A medical man had to write to the relatives of an intimate personal friend, Miss Ethel X. He could not, without a breach of professional confidence, inform them of his discovery that she was an alcoholic, much though he desired to do so. He was considerably startled when in due course it was brought to his notice that in his letter he had referred to her as " Ethyl."

Repression has nothing to do with ordinary forgetting. I forget the name of a casual hotel acquaintance with whom I played a round of golf last year. I cannot possibly have " forgotten " the name of a man with whom I have an appointment for next week. I wrote to him a few days ago and I see his brother repeatedly. Yet I have the very greatest difficulty in bringing his name to mind. The tendency to repression in this case is easily explained. The forthcoming interview will be a painful and embarrassing one, and distresses me every time I think of it. Further, the name is one which has very unpleasant personal associations for me, dating from an incident of many years ago. It is not surprising, therefore, that the ideas which the name represents and suggests tend to be shut off from that immediate and complete connection with my consciousness in which one might expect to find them in the circumstances.

Some years ago I was dictating a lecture in which I was comparing psychoanalysis to the rearranging the contents of an overfilled trunk, with easy subsequent closing. What I dictated, however, was " subsequent *clothing*."

A faithful study of one's own experiences in such matters as the forgetting of names, the mislaying of bills, the mistaking of messages, the failing to keep appointments, and so on, will furnish an ample supply of convincing illustrations.

We all know the man who is literally incapable of seeing facts which contradict his cherished theory, the man who cannot see the faults in his friend which are obvious to everyone else, and the mother who refuses to admit that her child has some physical or mental infirmity. (The student who desires further enlightenment on this point would do well to proceed to the out-patient department and have a word with the mother of a child suffering from, say, strabismus, or mental deficiency.)

It is a most instructive experience to be the third party to whom two opposed disputants confide, separately, their accounts of some stormy interview. However naturally sincere and truthful they may be, each will tend to give a report showing clearly that the dialectic honours of the encounter rested entirely with himself. The fact that points in the argument must surely have been scored by both of them is ignored, and each emphasises so strongly the points he scored, and makes so little of the spirited and scathing retorts of his opponent, that very soon he is sincerely and serenely unconscious that these latter ever occurred.

Another mental mechanism of the very greatest interest and importance in daily life is known as " Displacement of Affect." Like dissociation it is closely connected with superficial degrees of repression, and can be well enough defined and explained for our present purpose by saying that when some painful memory or situation or idea or fact is dissociated or repressed, the feeling or " affect " which belongs to it cannot, as a rule, be dealt with so easily. It refuses to go meekly into exile in a logic-tight compartment, or to be lost in the depths of the unconscious, but remains floating about in consciousness, divorced from its proper object.

Now this state of affairs cannot continue. Nobody can long remain merely " afraid " ; he must be afraid *of something*. You cannot just be " angry " ; you must be angry *with somebody*. Thus it happens that affect which cannot find its proper owner, so to speak, goes to and fro in consciousness in search of something therein which it can use as a substitute to which it can attach itself. It is not particular ; almost anything will do, and so " it generally happens that it hasn't far to go."

When a business man on his return home from work proceeds to scold his children, kick the cat and grumble at his dinner,

his wife understands (in, one hopes, a majority of cases) that these are not the things with which he is " really " angry. She does not suggest sending the children away to their grandmother, drowning the cat or—least of all—dismissing the cook.[1] She merely concludes that " something has worried him at the office." If he could fully realise this himself and had spent a few minutes before dinner telling himself just what he felt about his overbearing chief, the impudent office-boy and the insulting letter received from Messrs. Smith and Jones, he would no doubt still have been a tired and jaded man, but his angry emotion would have been attached to the proper objects and there would have been none to spare, so to speak, to slop over on to the harmless children and cat and cook. The irritating experiences have not, of course, been repressed in any real sense, but he has tried to gain relief as far as possible by " shutting them out of his mind " and turning away from them. His long-suffering wife can readily prove this for us, by asking him what has happened at the office to upset him. The probable reply will be a viciously snarled " nothing whatever," and matters will become ten times worse for the unfortunate family. From which we learn, *inter alia*, that there are occasions when tact and the spirit of scientific enquiry point in opposite directions.

The displacement of affect shown by a small child who has been hurt or frightened by a doctor—such things have happened—may be obvious for years and may colour the child's outlook and conduct throughout life. The doctor, let us say, has to change a dressing, and the child screams with pain. At the next and subsequent changes the child screams whether the proceeding is painful or not. When the doctor calls to attend to father's liver or mother's rheumatism the child screams at the mere sight of him, and in extreme cases the child screams at the sight of anybody who wears a black coat and striped trousers, provided, of course, that the doctor himself is addicted to such vanities. The child has displaced its affect of fear from the original doctor on to anyone who has the misfortune to resemble him, no matter how harmless his intentions or how distant his relationship. Let it be added that the responsibility for tragedies of this kind almost always

[1] This is a pre-war story.

rests neither with the doctor nor the child, but with the parents. But that is another matter.

"Once bitten, twice shy" is very understandable in the case of a small child and a savage dog, but what are we to say if the child carries into adult life a morbid terror of anything on four legs? At the moment we can just say "Displacement of Affect" and leave it at that. To take an illustration nearer home, we are all quite well aware that the particular object on which we discharge the venom of our wrath on one of those mornings when everything goes wrong is really a matter of chance. We are certainly not going to look fairly and squarely at the symptoms of the morning after and lay them to the charge of the night before. No, indeed. We are "out for trouble" from the start, and the moment of the explosion is merely a question of time. The hot water supply, the razor-blade question, the quality of the breakfast toast, the absence of marmalade—any of these matters will serve as the detonator, and should they all fail we have still an inexhaustible supply of pegs to which we can attach our sense of grievance, such as the non-delivery of the newspaper, the contents of the morning's letters, the prospect of the day's work, the unpleasing appearance of colleagues or the offensive bearing of teachers and examiners. Nothing can illustrate the matter better than the old story of the commercial traveller who, rising late the morning after a convivial evening party, arrived at the station after a desperate race of half a mile just in time to see his train gliding out from the platform. He turned upon a harmless porter who was quietly tying his bootlace and, finding him suitably placed for the purpose, he summoned his last remnants of energy and delivered a furious kick, exclaiming "Curse you, you're forever tying your bootlace!"

Now, as has been pointed out, no real depth of repression is involved in the instances of dissociation and displacement of affect just given. The unpleasant truths which are being avoided or ignored by the two quarrellers, the cat-kicking business man or the porter-kicking commercial traveller, cannot possibly have gone very far from consciousness. A few simple words would surely suffice to tear them from their logic-proof hide-outs and hale them to the bar of consciousness where judgment will be passed upon them. As their absence

therefrom was the cause of all the trouble it is natural to suppose that their reappearance will put things right. Yes, but it is not natural to suppose that consciousness will accept without some sort of struggle or protest the reappearance of material which she has already sentenced to prison or banishment. She is hard to beat and she realises very well that no sane man can deny a fact which is staring him in the face. So at the last moment, just as we are forcing upon her notice the unpleasant facts which are so grimly inconsistent with the scheme of things as she has arranged it, she plays her trump card ; the mechanism called Rationalisation.

She cannot bluntly deny the existence of an obvious fact, but she can and does seize upon it, manipulate it with lightning speed and dexterity, alter the light and shade on it, turn it inside out and, in general, so deal with it that its appearance and significance seem altered beyond recognition within a few moments. She can minimise it by stages until in a very short time it appears to vanish altogether, just as the conjurer performs the good old trick of the diminishing cards. Then, like the conjurer, she assures us that everything is fair and aboveboard, that all the facts have been duly weighed, that the proceedings throughout have been characterised by logic and sweet reasonableness, and that our judgment, not hers, has been at fault. The only difference, in fact, between the conjurer's performance and hers is that it is not the spectators but herself whom she usually succeeds in deceiving. That is rationalisation.

If consciousness finds, or fears that she will find, the full realisation of some fact or situation to be intolerable, the task of getting her to face it is often one of incredible difficulty. On occasion when, for one reason or another, repression and other devices are unsuitable or inadequate she plays her card of rationalisation, sometimes at the very first opportunity and sometimes as a last desperate measure. The intolerable fact cannot be excluded but it can be, and is, viewed through a distorting medium (as rationalisation has been aptly termed) by means of which it can be made to assume any desired shape. The illusion of logical thinking, reasoned conduct, and a consistent and homogeneous mind is thus temporarily preserved. We dress the wolf in sheep's clothing, turn him loose

in the sheepfold, convince ourselves that all will now be well, and go around telling the world that there really never was any wolf at all.

Now such a proceeding is clearly the reverse of logic, sincerity or commonsense, and yet its whole object is to convince ourselves and others that these are the very qualities which govern our thought and conduct. This passion for making illogical things appear logical is universal. Perhaps it is because the success of those methods of ordered thought, calm reasoning and impartial judgment, which are so admirably suitable for, say, a scientific research or a criminal trial, leads us to the false assumption that life, like them, is a logical proposition and must be dealt with by the same methods. Be that as it may, it is certain that most of us spend a large part of our time in distorting facts to suit ourselves while proclaiming with pathetic insistence that all we are really doing is seeing life steadily and seeing it whole.

To such lengths does this go that even when there is no particular psychological reason why we should not admit some inconsistency in conduct, or some illogicality in a decision, the very idea that we could possibly commit any action which we cannot explain on logical grounds to our own entire satisfaction is, to many of us, quite intolerable. This is why rationalisation plays such a large part in everyday life as well as in the symptomatology of profound nervous and mental disorder. It is also why so many people spend so much time in manufacturing a " reason " for everything they do.

We all know—or ought to know—that life is not a logical proposition and that, even if it were, the driving power of reason alone is as nothing till it receive energy from harmonious combination with instinct plus its affect. People do not do great things because they *think* they are right ; they do them because they *feel* they are right. This truth, which is really elementary, has been expounded for centuries by numberless writers, philosophers, poets and psychologists. G. K. Chesterton, to give but one instance, deals with the matter in his *Orthodoxy* in inimitable style, concluding by pointing out that whereas the mystic only seeks to get his head into the heavens, the logician seeks to get the heavens into his head—and it is his head that splits.

But the rationalising addicts still insist that reason is the senior partner, or rather the prime minister, and instinct merely the unpleasant leader of a small and disreputable opposition. They are a formidable company, too, but the truly remarkable thing about them is that they are almost completely impervious to argument. The only way in which they can preserve the illusion that their lives are ruled by reason is by a process which is itself the very negation of reason. To become the complete rationalist in one's own eyes it is necessary to become " deafer than the blue-eyed cat, and thrice as blind as any noonday owl " in the eyes of everyone else.

Such proverbial sayings as " A man convinced against his will is of the same opinion still," and " There are none so deaf as those who will not hear," among many others, illustrate the point.

To have a plausible " reason " ready at hand to " explain " one's every action is an exhausting business, and under pressure the " reasons " soon begin to shed their plausibility and to lose what little connection with the matter they may ever have had. Particularly is this so when, as often happens, there is not a " reason " in stock, so to speak, and one has therefore to be improvised. In such cases it is often impossible to prevent its being recognised for what it really is—no reason at all, but a justification or excuse, thought of after the event. Sometimes the " reason " is a blatant absurdity, but the good rationaliser shows an amazing ingenuity and resource and can often give a momentary air of plausibility to even the most ridiculous irrelevancies.

The slogan of rationalisation is " I can explain my position." It is clear that the life of the mental hospital " Queen " who works daily in the scullery must be one long series of rationalisations unless she abandons either her claims or her occupation. If the man who believed himself to be a poached egg had ever existed, one would almost think that the energy and ingenuity he must have devoted daily to explaining and rationalising his position would in themselves have been sufficient to convince him of his error. Psychotic patients, however, will often attempt such feats of rationalisation without hesitation. They have the advantage, as a rule, of caring a good deal less for convention or probability than the average person. A patient

did once exist who believed himself to be the great Napoleon. One day he carelessly announced himself to be the Duke of Wellington, and when reminded that yesterday he was Napoleon, he instantly replied, "Yes, but that was by another mother!" Another patient who was found with his head at the foot of the bed and his feet on the pillow, explained his position without difficulty by saying that he was "what the doctors call a breech case."

But we are concerned with much more modest examples of rationalisation than these fantastic specimens. When, owing to a regrettable error of judgment, you led the Queen of Spades instead of the Four of Hearts at a recent bridge-party, it is pretty certain that unless, like Glendower, you are not in the roll of common men, your mind was working feverishly for the rest of the hand, manufacturing "reasons" for the lead which might possibly be accepted by your implacable partner. Further, you elaborated them so earnestly and compensated so skilfully with your ever-increasing emphasis and eloquence for their ever-decreasing relevance and credibility that before you reached home you believed firmly in them yourself and were prepared to justify the lead before any bridge expert in the country. In fact, you made a note of how the cards lay and expressed the intention—which you have not carried out—of writing to a bridge magazine about it. Your "reasons" did more credit to your ingenuity than to your reasoning powers. After a short preliminary skirmish about informative bids you called the play of the previous trick in question and proceeded to credit yourself with having correctly "placed" cards of whose whereabouts you had no notion till they fell. When the atmosphere had been raised to a suitable temperature you committed a painful lapse in logic by making hurry, noise, bad light and an uncomfortable chair contributory causes of your splendid lead, and you ended triumphantly by pointing out that your partner should have been working for his exam. and had no business to be playing at all. To such antics is rationalisation apt to lead us.

The M.P. who crosses the floor of the House traditionally makes a personal statement explaining his position, which is hailed as a masterpiece of manly sincerity by his new party and regarded as one long rationalisation by his old one. All

political activity, for that matter, is the happy hunting-ground of rationalisation, and a general election is its very apotheosis.

It is very questionable whether a purely intellectual appeal would bring twenty per cent. of the electorate to the polls but, as every election agent knows, an appeal to the emotions, no matter how irrelevant, is almost irresistible to the average voter if skilfully disguised as an appeal to his sturdy British commonsense.

Some time ago I observed on a hoarding a poster depicting a white-haired old lady of saintly appearance. No clue to her identity, character or political views was given, but beneath the picture was printed the simple exhortation : " Vote Labour —*for her* ! " To avoid any suspicion of bias I hasten to add that within a few yards of this masterpiece was a picture of an attractive young lady of singular nobility of countenance inviting all and sundry to vote Conservative because " only youth can understand the problems of youth." " Fallacy somewhere, I fancy," as the ghost in *Ruddigore* remarks.

In a world of broken promises, neglected duties, forgotten engagements and the like, none of us has far to look for abundant instances of everyday rationalisations which are current coin in our social life. Nobody believes them, not even those who perpetrate them, but they do little or no harm and most people prefer them to the blatant rudeness with which certain eager young spirits break the bonds of worn-out convention. But however automatic our production of rationalisations may become, it is well not to be too careless and suggest that an event of yesterday was the cause of something which happened a week ago. Only the White Queen could get away with that.

Hardly ever does the average adult find himself at a complete loss for a rationalisation of some sort, though now and then one finds that a child will answer an embarrassing enquiry with " just because," and leave it at that. A similar poverty of invention was shown by the little fishes of the sea in *Through the Looking-Glass*. The more promptly a rationalisation is produced the more effective is it likely to be. When your friend comes to you on Thursday to explain his reasons for acting as he did on Tuesday you are justified in suspecting that he spent Wednesday in inventing them.

The scope for rationalisation which general medicine offers

to both doctors and patients is enormous, quite apart from the grotesque absurdities of psychotic patients already mentioned. This is natural enough because there is no sphere in which a logical sequence of cause and effect is more earnestly sought and none in which it is more difficult to produce.

The first and insistent question which comes to the mind of anyone experiencing a physical or emotional disturbance of any kind is "What is the cause of this?" and very few indeed will be satisfied until an answer of some sort has been provided.

Very often an adequate answer is either quite impossible to give, or would be incomprehensible if given. Few physicians have the courage to say "I don't know," and still fewer patients would appreciate the wisdom of such a reply were it made. So the physician embarks on that riskiest of all procedures, the exposition of pathology to a lay person "in words of one syllable" and the patient combines the doctor's pronouncements and his own theories—often with startling results. Few among us can suffer the pains of dyspepsia without making a critical review of everything that has passed our lips for days. We strongly suspected that curry, but enquiry by telephone shows that the two others who shared it with us suffered no ill effects. At last we run the thing to earth; it was that tinned salmon of which we, and we alone, partook not wisely but too well. "It is the cause, it is the cause, my soul," and whatever the state of our gastric mucosa, our soul is at once in comparative peace. What on earth can have been the "cause" of this or that attack of rheumatism, fibrositis, sciatica, toothache, coryza, palpitation, vertigo and so forth? Unless the patient has been lying alone in a dark room for a week—or even if he has—it will not be really difficult to concoct a plausible story of cause and effect, which may even be true, now and then. But the plausibility is the thing. To see it really artistically done you should study death-certificates. To observe painfully made attempts at it you should visit V.D. out-patients.

Every depressed patient is quite certain that he knows the "cause" of his depression, and, as you will learn in due course, the rationalisations of a true melancholic can be as fantastic as anything in psychiatry. The rationalising performances of a patient's friends, however, are more important to the student

at this stage, and should be carefully studied at every opportunity. There seems to be literally no limit to the lengths to which they will go in attempts to explain, justify or excuse some eccentricity or abnormality in a patient. They relate it to some past event or present circumstance which could not at most be more than a very minor factor in the causation and usually has nothing whatever to do with the matter. Further, they invariably attribute to the most trivial happenings an almost incredible potency for evil. A fall in childhood is made responsible for the onset of such disorders as poliomyelitis or disseminated sclerosis, a knock at football fifteen years ago is the cause of a carcinoma, and the most profound psychotic depression is regarded as the natural consequence of the "shock" sustained by the patient on hearing of the death of his mother-in-law.

It is vitally important that the student should understand why these perversions of clear thinking—and others shortly to be discussed and exemplified—originate in the minds of patients and their relatives. Only when he does so will he be able to recognise them promptly and deal with them kindly and effectively.

It may be mentioned in conclusion that Antonio in *The Merchant of Venice* is the one depressed patient who is known to have stated bluntly that he did *not* know the cause of his depression. His friends, however, are typical "patient's relatives" and supply rationalisations in characteristic style. Their certainty that "he only needs to be cheered up," and their efforts towards that end, are in the best tradition. But it is very doubtful if Antonio was a true melancholic. His recovery at the very end of the play, immediately upon getting a piece of good news, is atypical and unconvincing. It rests on his unsupported statement and I am disposed to give more credence to the crisp if colloquial self-diagnosis of his penultimate remark: "I am dumb." Perhaps we should hardly expect a friend of Bassanio or, for that matter, Gratiano, to be anything else.

Chapter 6

PROJECTION AND PHANTASY

We have now to consider what is perhaps the profoundest and most subtle mechanism of all, although at first sight it appears to be one of engaging simplicity. Its name is Projection, its slogan is the venerable one : " It wasn't me," and the first recorded use of it took place in the Garden of Eden. Since that occasion it has become universally popular, and its slogan has been agreeably varied to suit differing tastes and circumstances. Such familiar phrases as : " You're another," " It came away in my hand," " I can never play decently with borrowed clubs," " Students nowadays can't understand plain English," are all variations on projection's main theme. The interesting thing about them is that on a given occasion any or all of them might well be perfectly true, but they are all illustrations of projection, nevertheless.

Projection is a compromise which we all tend to adopt when some idea, the full realisation and acceptance of which would be intolerable, threatens to break through the barrier of repression into our consciousness. We are forced to acknowledge the existence of the offending idea, but we dispose of it the very instant it appears by attaching it to something or somebody in our environment. We disown the idea, we deny all parental responsibility for it, so to speak, and we say, in effect, " Yes, it exists, no doubt, but it doesn't belong to me. Ask the people next door. I think it's theirs."

This procedure makes it easy for us not only to admit our own failures, mistakes and less desirable tendencies, but to criticise and deplore them to our heart's content, because we have disclaimed all personal connection with them and have attached them firmly to outside objects or persons. A bad workman blames his tools. Yes, and the worse workman he is, the more vigorously and bitterly will he blame them. It must be noted, too, that he will have an eagle eye for any defects that may actually exist in his tools. Like rationalisation, with which superficially it has something in common, projection

automatically makes the best and most logical case it can for itself. Only as a desperate measure does it hurl material into the environment completely at random.

Projection goes further than rationalisation in that it is counter-attack rather than mere defence, a denial rather than a justification.

It is the muddle-headed man who announces with peculiar heat that not one of his colleagues in the office is capable of presenting a clear and concise report. (He will, of course, " prove " his thesis by very special reference to any unfortunate colleague who does, in fact, happen to lack that ability.)

The man whose social status is doubtful and whose standard of manners is not beyond criticism often keeps himself from realising the fact by endless talk about " snobs " and " cads " and " outsiders," enlivened with stories of the social lapses of people who were " not quite gentlemen."

Such everyday instances of projection as these are abundant, and it may be added that they are usually characterised by a peculiar emotional warmth and an air of injured and indignant innocence which makes them readily recognisable. The savagery with which certain women condemn the frailties of their erring sisters is proverbial. Those who do so are those who are afraid to admit even to themselves that they share the weaknesses and follies of humankind with the rest of us. They dare not abandon their position, and to maintain it they have to become more royalist than the King and gain what relief they may by merciless denunciation of their own tendencies as reflected in the conduct of others. Those who have even the beginnings of real self-knowledge will be the last to condemn, and will say instead, in the words of the old story : " There, but for the grace of God, go I."

But projection goes much deeper than has yet been indicated, and though it cannot be adequately dealt with in brief summary a few further points may be mentioned which will well repay study by any student who has the opportunity and inclination for it. Projection is closely connected with the virtues of sympathy and tolerance and is at the very root of both appreciation and censure—indeed, of all criticism, apart from the passing of purely intellectual judgments. It is not really hard to understand why this is so. We can only see what is " in us "

to see, and we are incapable of seeing, recognising or appreciating anything else. A small but highly intelligent boy who had just mastered the first seven letters of the alphabet remarked on seeing the word BANK in large gilt capitals over its door: "Look! Stupid! It should be A. B." N and K meant nothing to him, nor had he any idea that letters could be combined and arranged in various ways and indeed existed for that purpose. But he did know that B comes after A and not before it, and he was quick to recognise and resent any tampering with his established scheme of things.

A very young child will greet a picture of some bearded personage such as King Lear or the prophet Elijah with a gleeful shout of "Daddy!" should his father be similarly afflicted, and will completely ignore a multitude of striking dissimilarities. The same result can be achieved by making a kilt or a top hat the basis of the experiment.

If what is "in us" to see happens to be so emotionally upsetting that we cannot face it as it appears in ourselves, we shall be all the readier to look at its reflection in other people—the only means by which we can safely express our feelings about it. Though it is far from a complete analogy, the legend of Perseus and Medusa has some features which inevitably suggest themselves in this connection. The originator of the fable that Perseus cuts off Medusa's head with averted eyes while he looks at its reflection in the mirror of Athena's shield must have been a natural psychologist of no mean order.

It is obvious that you cannot truly appreciate a picture unless you are at heart—though not necessarily in performance—an artist. You cannot understand a piece of music unless you have, as we say, "music in you." In the same way you may be quite sure that when you react to conduct in your neighbour with that peculiar emotional warmth which we all know, it is conduct of which you are certainly capable, though not necessarily guilty, yourself.

You cannot understand conduct which is completely foreign to your own nature, and you are therefore little concerned either to admire or to censure it. King Arthur's heart, you may remember, was "too wholly true to dream untruth" in Guinevere. Sexual infidelity being — as we are told — completely alien to his nature, he was incapable of even suspecting

it in others. It is literal fact that we have within ourselves a responsive sympathy, partially or totally unacknowledged, with every act of others which we whole-heartedly and emotionally praise or condemn. The less the tendency is acknowledged in ourselves the more intense is the reaction likely to be. "It was not I!" cries projection. Dear Sir, it *was* you, and that which you have recognised and denounced in another is a portion of your very self which you are trying to disown and cast away.

Now, though projection, like the other mechanisms, is a feature of normal daily life, it is a dangerous expedient if one resorts to it too readily and takes no steps to acquire the self-knowledge which makes it needless and impossible. One cannot go on hurling parts of one's own personality away into one's environment without penalty. The penalty is simple enough and very appropriate. The environment acts much as the wall against which we throw a tennis ball. The ball returns to the thrower at a different angle and with a force proportionate to that with which it was thrown. The offending idea, that is to say, will return in a new but complementary form, and will appear to have come from some part of the environment, but it is a return journey for which the environment is in no way responsible. The ball rebounds from the wall because it was first flung there; action and reaction are equal and opposite. The patient who projects unacknowledged aspects of himself into his environment will surely receive them back again, and we need not be surprised if he has difficulty in dealing with the rebound.

A man casts away the idea that he is deceitful and receives back the suspicion that he is being deceived; he disowns his feelings of envy and malice, but receives in exchange the conviction that implacable enemies seek to murder him; he stifles all attempts at self-judgment, only to become maligned and slandered by hallucinatory voices.

In other words, projection is the mechanism chiefly involved in delusion formation, and is of immense importance in its relation to various psychotic states.

Here we must leave the matter and proceed to consider almost the last mechanism which we need call by that name. In projection, which we have just discussed, we may picture

the individual as more or less standing his ground, but hurling realities away from him when they show signs of breaking through his defences. On the other hand, we may imagine him adopting quite different tactics to achieve and maintain an avoidance of painful reality. We may picture him as shutting his eyes to the world of reality which is both around and within him and withdrawing into a private unreal dream-world of his own creation. We can avoid the company of an intruder either by throwing him out or else by running away ourselves. Either plan may be preferable, according to circumstances. Both methods are constantly adopted by the mind in dealing with intolerable ideas, and the name of the " escapist " method which we are now to consider, is Phantasy. Its slogan is " Let's pretend," or " Just you wait," and most of us find that, carefully added to our daily life and thought in small quantities it produces a beneficial stimulating effect. Unfortunately it is habit-forming, and several cases of addiction were reported in the period from September 1939 to the General Election of 1945. Since the latter date many of the patients have made a very rapid recovery. The earliest symptom of overdose is popularly called Wishful Thinking.

Phantasy, as we have already seen, is essentially nothing more than a reversion to the picture-making, satisfaction-seeking, reality-ignoring methods of the unconscious mind, and the inadequacy of these methods to give permanent satisfaction in a real world need not be further emphasised. It is the same old story. You may escape from your troubles, you may settle your problems, you may remould this sorry scheme of things in complete accordance with your heart's desire and you may do it now, in the twinkling of an eye, provided that you pay the price which is that you do all these things in a dream world, to enter which you must divorce yourself from reality. It is all very splendid and very wonderful, but—it is not real. The fulfilled hopes, the achieved ambitions, the satisfied desires, the eased worries, the solved difficulties form a glittering procession indeed, but at the touch of reality the insubstantial pageant fades on the instant, leaving not a rack behind.

Now that is a high price to pay, but we all pay it gladly time and again. After all, one does not expect to get into wonderland for nothing. Some people find the cost heavier than

others. Children in arms, I believe, are admitted free, and those under twelve pay half-price. It is not until later that make-believe and reality are totally at loggerheads, and that "It might be" is completely "baulked by 'here it cannot be'."

But at any cost we all contrive, now and then, to escape into the land where dreams come true, and if due precautions—chiefly with regard to the return journey—are taken, periodic excursions do good rather than harm. Phantasy will sometimes help when nothing else can. A day-dream can be a refreshing and inspiring thing and, if the goal be not an utterly impossible one, the vision of it attained may be highly stimulating and practically helpful when one comes back to the weary task of struggling towards it in the workaday world. Only, remember, you must come back. Phantasy is an excellent servant but a bad, bad master. The penalty for overstaying one's leave in dreamland is a hard one. The dream world becomes more real than the real world, and the dreamer is cut off from effective contact with real life altogether. Many such dreamers are to be found in the chronic wards of mental hospitals. We all build so many dream worlds of our own that it is not difficult for us to imagine a patient seeking permanent instead of momentary shelter in a lifelong day-dream, choosing the world of fancy as his real world, and paying the price—divorce from reality—with a smile. Some reality was an intolerable load or an insurmountable obstacle ; he chose to escape it by becoming the hero of a fairy-tale—and it will never trouble him again.

It has already been pointed out that all the mechanisms we have discussed are illustrated both in the conduct of everyday life and in the symptomatology of nervous and mental disease. It is in the former respect that we are concerned with them, and they are not therefore to be regarded as truly pathological processes at all for the purpose of our study. We should rather think of them as comparable to the expedients and devices—sometimes obvious antics—to which the indifferent golfer resorts in attempts to cure his "slice" or doctor his ailing swing. But if one invites questions after a lecture on mental mechanisms one is invariably faced with a demand for a categorical statement as to whether they are

" normal " or " abnormal." One can understand the student's desire for a clear-cut answer, though it cannot be provided at this stage beyond saying that it is largely a matter of degree. A comparison of the relation of the mechanisms to mental health with that of alcohol and tobacco to physical health may perhaps help to give a reasonably accurate view of the question, though the analogy is by no means close or complete. Few would deny that alcohol and tobacco can be so used as to be not only harmless but of definite physiological benefit while at the same time they make life an easier and pleasanter thing than it would be in their absence. On the other hand, we are all very well aware that they can be so used as to be important factors in the causation of many serious illnesses. If it were legitimate to push the comparison further, teetotalers and non-smokers would presumably correspond to those persons who have undergone a complete Freudian psychoanalysis and whose personalities are therefore totally free from irrationality of any description. It is perhaps fortunate that most of us shrink from joining these diehards in the discomfort of the last ditch, and are content to remain " creatures not too bright and good for human nature's daily food."

We certainly must admit that ample provision is made for our amiable little weaknesses. For example, if we wish to save ourselves the trouble of making our own rationalisations, all we need do is to purchase a newspaper of suitable political complexion, where we shall find an ample supply of them all ready for use. In the same way very many people prefer to have their phantasies ready-made, like the man who lacks the energy or the skill to roll his own cigarettes. This need has been recognised for centuries and can be simply satisfied nowadays by the purchase of a novel or a seat at the theatre or cinema. It is clear, by definition, that the most satisfying phantasies are those associated with our deepest instincts. Hence the eternal popularity of adventure stories and love stories. By the simple process of Identification, the completeness of which tends to vary with the individual's standard of education and intelligence, we personally share to a greater or less extent the trials and triumphs of some selected character in the book we read, or the play we attend, and we may even " register " the appropriate emotions as faithfully and thoroughly as if we were

personally involved. So far may this process go that even today theatres—and plays—are to be found in which the baffled Sir Eustace is in danger of suffering bodily harm, not from the saintly hero but from missiles hurled in righteous anger by the less sophisticated members of the audience.

Now it has already been emphasised that these mental mechanisms do not function separately from each other. They are not mutually exclusive like radio programmes on different wave-lengths, though we have had to consider them apart from each other for the purpose of elementary definition and explanation. It has also been pointed out that we are not now concerned with an advanced study of any of them, least of all in their relation to nervous or mental disease. Our business with them is to show how they colour and affect the whole of our daily life and intercourse, and, therefore, how immensely an understanding of that aspect of them will facilitate what we have called " the human approach " to our patients, and will clarify all our dealings with them.

It is, therefore, in the wards and even more in the out-patient department that the student should take every opportunity and make every effort to recognise them at work. At the same time he can derive much innocent enjoyment as well as profit from observing their influence in the characteristics and peculiarities of his relatives, his colleagues, his teachers and—very rarely of course—himself.

The following paragraphs consist of further illustrations drawn from various sources, and the student is left to " spot " the different mechanisms concerned for himself.

He may well begin with extracts from what is probably the most concentrated dose of bad advice ever administered : John of Gaunt's speech in *Richard II*, to his son Henry Bolingbroke, on whom sentence of banishment has just been passed :

> " All places that the eye of heaven visits
> Are to a wise man ports and happy havens.
> Teach thy necessity to reason thus ;
> There is no virtue like necessity.
> Think not the king did banish thee,
> But thou the king."

" Go, say I sent thee forth to purchase honour
And not the king exiled thee ; or suppose
Devouring pestilence hangs in our air
And thou art flying to a fresher clime :
Look, what thy soul holds dear, imagine it
To lie that way thou go'st, not whence thou comest :
Suppose the singing birds musicians,
The grass whereon thou tread'st the presence strew'd,
The flowers fair ladies, and thy steps no more
Than a delightful measure or a dance ; "

When Falstaff is caught abusing and slandering the Prince among his low companions in the tavern, he replies : " I dispraised him before the wicked, that the wicked might not fall in love with him ; in which doing, I have done the part of a careful friend and a true subject."

To witness a mother slapping, shaking and scolding the small child whom, by her own neglect, she has allowed to be nearly run over by a motor-car, is a most instructive though saddening experience. To hear an altercation between two taxi-drivers who have just escaped colliding with each other is equally instructive and more amusing. A similar experience can also be gained, but in a more expensive and possibly humiliating way, by the offer of an inadequate tip. A middle-aged lady of my acquaintance who had just completed three years' work in a munition factory was rash enough to say in reply to the taunts of a bus conductress, of whom she had dared to enquire when the bus would start, that she was a worker, too. She was at once informed, *coram populo*, that it was people like her and Winston Churchill who had led the country into war.

Many years ago I was instructed to discover from an ill-prepared student why he had failed to score more than a negligible number of marks in an examination. He said he was glad to have the opportunity of telling me that, in his opinion, the examiners were incompetent and should be ashamed of themselves. He supported this view by pointing out that he had thoroughly studied the complexities of the subject and had been most unfairly faced with a paper on its elementary beginnings, which he had very naturally overlooked.

Longer ago still, a small boy lost a golf match against his brother for a coveted prize. At the end of the match he assumed his brother's name, walked boldly up for the prize when that name was called out, and refused to answer to his own for some hours.

A medical friend once showed me an old notebook in which, mixed up with much illegible material, I was interested to observe his signature with a large number of degrees and qualifications appended. I remarked that I had not known that he was both F.R.C.S. and F.R.C.P. " I'm not," he replied. " I remember writing that just after I had come down in anatomy for the second time."

I conclude with two illustrations which are really more suitable for the chapter on " Psychiatric Oddities," but are set forth here in the hope that the student may be more successful than I was in determining the precise mechanisms involved. At least they illustrate the incredible antics which the minds of the reputedly sane are capable of performing.

I had just seen a clergyman's wife who was in a pitiable state of bodily and mental exhaustion, largely due to years of drudgery as her husband's unpaid housekeeper and maid-of-all-work. After the consultation I asked him if he had not noticed any falling off in interest and energy, or other signs of fatigue, on the part of his wife. After some thought he replied : " I can assure you, Doctor, there has been nothing of the sort. She keeps my clothes splendidly and she is an excellent cook." I asked him if he could tell me who said " Is not the life more than meat and the body than raiment ? " whereupon he told me that I was " wresting scripture," and we parted in some haste and without the customary compliments—or the customary fee.

A less unpleasant but equally startling experience was my interview with a gentleman who had called, he said, to please his wife, but had no desire to have my opinion about himself because, like all other doctors, I was careless, worldly, deep in sin and carnally minded, whereas he was doing " the Lord's work " and there could thus be no sympathy between us. I asked him his occupation and was told that his occupation was to do God's work by showing people like myself the error

of their ways. I pressed the question and he finally said : " Yes, I was once like you, dead to higher things. In those days I had an occupation : I was a carpenter ! " I told him that surely in one instance at least, following the calling of a carpenter and " doing God's work " had been successfully combined. He said " pah ! " or words to that effect, and walked out.

Chapter 7

SYMBOLS AND CONVERSION

Having surveyed the most important mental mechanisms, we must now go back a little and look at the struggle between repressed material and repressing force from a slightly different view-point. Let us return to the analogy of the disturbance at a public meeting, which was given in chapter 5.

So far we may be said to have studied some of the motives and methods of the interrupters and also some of the efforts of the unfortunate chairman to dodge the missiles they hurl at him, but we have not considered the nature of the missiles themselves. Why did they fling a dead cat instead of an egg or a tomato? If the answer to that is too obvious let us ask instead if they flung a half-brick just because it was there and if a stone would have done just as well.

The answer is that they chose the missiles most appropriate for their purpose from among the objects which were lying around, but their choice was clearly very limited. The analogy thus fails to illustrate the almost uncanny *appropriateness* to each individual case of the results of intrapsychic conflict, be they definite neurotic symptoms or merely minor eccentricities of conduct or alterations in character.

Now to deal fully with this question here is impossible because it leads us at once not only far into highly specialised theories of psychopathology and treatment, but right on to the essential characteristic of psychoneurotic symptoms as opposed to all others, namely, that they depend upon the mental life of the individual concerned, are peculiar to him alone and could not possibly be experienced in their details by anybody else. The vermiform appendix, or the kidney, or, for that matter, the brain of John Smith may be indistinguishable from those of John Brown on an adjacent shelf in the museum. Further, these persons may both have been "typical cases" of appendicitis or nephritis or anxiety neurosis, but John Smith's obsessions or phobias or dreams were peculiarly his

own and could never have been experienced in their details—which really means, in their essentials—by John Brown or anybody else. That is the central fact upon which all psychotherapy depends. It is thus far beyond the scope of our present study. Some reference, however, must be made to it if only to prevent the student falling into the sadly common error of thinking that labels such as "neurosis," "obsessions," "? mental" and so forth are adequate diagnoses, or pointers to correct treatment. There are occasions when one cannot, at first, get much further than this, just as there are occasions when the surgeon has to be satisfied with the diagnosis of "acute abdomen," but the surgeon has at least some idea of the probabilities before he operates, and his efforts are directed to finding out the exact state of affairs at the earliest possible stage of the operation.

It is an error not to see the wood for the trees, but it is also an error, and in psychological medicine a much commoner and more serious one, not to see the trees for the wood. The student who regards "mentals," "neurotics" and so forth just as so many large groups, each with its routine treatment, is falling into this error. Any fool can recognise a flock of sheep when he sees it, but it takes a shepherd to distinguish each individual sheep from all the others.

How, then, without embarking on a specialist course of study are we to learn something about the "individual" nature of psychoneurotic symptoms? We may note, in passing, that we saw some indication of it in our discussion of projection. In that mechanism we saw that the intrusive belief or suspicion which appears to its victim to come from outside himself is definitely and demonstrably complementary to the intolerable idea which he has disowned and attempted to cast away. We shall need more than this, however, to help us to understand why, in psychological matters, "the punishment fits the crime" with such unerring accuracy.

In an earlier chapter it was stated that in daily life we all tend to express ourselves in the psychological shorthand of gesture, symbol and imagery whenever we can, and we may begin our present study from that point.

A symbol is much easier to illustrate by example than to define—a fact which I have just confirmed by consulting the

dictionary. Let us take it for granted, then, that of course we know what a symbol is, and proceed.

The use made of symbols in our daily speech and thought is enormous, and the amount of time and trouble saved thereby is incalculable. We meet an officer in uniform and within a few moments we are in possession of a remarkable amount of information about him. We "see," for example, that he is a major, that he is a doctor, that he has served in two wars, that he has been wounded, that he was between two and three years overseas, that he was mentioned in despatches and that he has been awarded a decoration known as the Military Cross. We come by all this information, not because he carries a placard announcing these facts, but because he carries a few pence worth of metal and ribbon arranged in certain ways; things of little or no intrinsic worth which have ideas attached to them—that is to say, symbols.

Many of the things we prize most dearly have their worth not in themselves but in the ideas for which they stand. It is truly startling to consider the immense number and the tremendous significance of the ideas which can attach themselves to trivial objects such as a picture, a badge, a flower, a flag, a "scrap of paper." A rose, a ring and a cross—to name what are probably "the big three" in the world of symbols—stand for ideas which a lifetime of speech and writing could not fully express.

Needless to say, when symbols are used and symbolic acts performed, all the parties concerned must know what the symbol stands for and it must stand for the same thing to all of them. To raise one's hat to a lady in the East who was unaware of the symbolic meaning attached by us to that strange and irrational act would earn one a reputation for eccentricity. This would be enhanced if one failed to take off one's shoes on entering an Eastern place of worship. A few symbols are well nigh universally understood, but to many others one very often does not know the key, and the symbol becomes useless and misleading until one finds it. It must also be remembered that the same symbol may mean utterly different things to different people, or even to the same person at different times and in different situations.

All this could be elaborated at great length, but it is really

only a preliminary to the point which is our immediate concern. All that has been said about the use of symbol and imagery by the conscious mind applies with infinitely greater force and significance to the unconscious. To the conscious mind, symbols are the language of choice and convenience, but to the unconscious mind they are the language of necessity because it has no other.

We have already seen that the constant aim of repressed material is to gain entrance to consciousness and express itself there. To succeed in this aim it must be so altered in appearance that its true nature will not be recognised by the conscious mind. Otherwise it would of course be inviting instant expulsion, or re-expulsion, if indeed it ever succeeded in evading the vigilance of the repressing forces at all. We know that it can only express itself in imaginary " pictures," and it thus follows that these pictures must be distorted and disguised by some means or other if they are to avoid repression and enter consciousness unrecognised.

Symbolisation is one of the most important of the many means adopted by the unconscious mind for this purpose, and the ingenuity and variety of the symbols employed is truly amazing. The conscious mind is literally presented with a picture puzzle or rebus, of the kind which used to be popular in magazine competitions—ideas, as ingeniously disguised as possible, expressed in pictures. Now this process obviously has its limits in ordinary sane waking life. Consciousness is highly suspicious of anything which looks like disturbing its apparently calm and even flow, no matter how gently the intrusion is effected or how innocent the intruder may appear. The powerful mechanisms of rationalisation, projection and the rest are all on the alert to keep the peace, so that any idea, imagination or impulse which is not in reasonable harmony with consciousness's ordered scheme of things is under observation from the start, and is often arrested and dealt with for " behaving in a suspicious manner " long before its disguise has been penetrated and its true identity established. So long as a person retains his grip on reality and his healthy contact with his environment, consciousness will have little difficulty in dealing with these psychological gate-crashers.

But when is a normal person's contact with his environment

least adequate and his hold on reality least secure? Obviously when he is asleep. That would thus seem to be an ideal time for repressed material to make a special effort to express itself in consciousness which, during sleep, is so dim, so vague, so deprived of its highest functions such as those of criticism and judgment that it will accept without alarm or surprise almost anything which is sufficiently disguised to evade repression, which, though by no means "off duty," is taking things much more easily than in waking life. Such a special effort is in fact made, and the result is a dream.

A dream is an idea expressed in a picture. To realise something of the limitations and difficulties involved the student has only to take pencil and paper and try to express some given idea in a drawing or series of drawings. He will speedily find himself, like the picture-writers of ancient times, at a loss to discover means of indicating moral values, comparisons, alternatives, conditions, probabilities and so on, and, like them, he will have to make use of symbolism, distortion, caricature and endless other devices with all the ingenuity at his command. A cartoon forms an excellent analogy to a dream with the additional point of similarity that its central idea is very often one which if openly expressed in words might involve the author of them in a libel action or other unpleasantness. A cartoon, while conveying its message unmistakably and vividly to the intelligent public, must do so in such a fashion that it shall pass the censor and that it shall not give grounds for an action at law on the part of those it victimises. As we all know, all kinds of devices such as double meanings, plays on words and symbolism of every description are quite legitimate in cartoons and are expected and readily understood by those who look at them. Further, it is upon just such details that the whole significance of a cartoon usually depends, and the immense condensation and compression of ideas which their use brings about results in a corresponding degree of vividness and point. A study of a few good cartoons would make all these points abundantly clear.

A dream may also be most helpfully compared to a charade—an impromptu play whose object is to present a word to the audience in some clever disguise. The "properties" are taken from those articles of furniture or clothing lying around which

happen to be best adapted for the purpose. Thus, a golf-club may be used as a sceptre or an oar or a fishing-rod *or a golf-club*, as the charade may require. The word is expressed syllable by syllable in successive scenes, each of which appears meaningless by itself until seen in its proper relation to the whole. All sorts of puns and other inconsistencies and absurdities are not only allowable but are taken as matters of course. For some reason which I cannot understand it is almost impossible to make the average student realise that the unconscious mind uses precisely these absurdly childish devices. As it is, by definition, childish and uneducable, this is just what we should expect it to do, and it would be most surprising if it were to do otherwise. The people who " can see no sense " in dreams but who unhesitatingly accept a child with dressing-gown, sofa cushion, dish cover and six girl friends, as the living representative of King Henry VIII are surely straining at a gnat and swallowing a camel.

Now it is unnecessary for us to go further into the matter of symbols and dreams at present. We are already on the brink of questions of psychopathology and psychotherapy which are the concern of the specialist in psychological medicine. It is, however, of the greatest importance that the student should have some general idea of the facts and theories which underlie what is one of the most fascinating, the most difficult and the most important of psychological studies. Even though he may never learn more than the elementary outline here presented to him he will find that smattering of incalculable use to him in almost any branch of medical practice. It will at least enable him to give some sort of an answer to the questions which his patients will certainly put to him on these subjects. Whatever the nature of their illnesses, almost all patients have an insatiable thirst for information on psychological matters. It is true that the doctor is no longer regarded as an almost omniscient being whose word is final on all subjects connected with medicine, but this makes it all the more necessary that he should have some views to express and something intelligent to say about them in reply to patients' questions. The man in the street has become a veritable addict to popular psychology, and his questions are infinitely more searching and sophisticated than they used to be. Their tone, too, is much more

argumentative and, in general, if the doctor has not got some sensible, or sensible-sounding, views on such subjects as dreams, anxiety-states, Christian Science, " faith healing " and all the rest of it, to express crisply and clearly to the patient, their rôles may very easily be reversed and he may find the patient expressing his views vaguely but at interminable length to him !

But the chief justification of this chapter lies in the fact that it is a necessary introduction to a short account of the very remarkable process called " conversion." It is the last of the mechanisms which we shall discuss, and it has not been mentioned previously because it differs in one very important respect from all the others. It has repeatedly been emphasised that minor degrees of dissociation, rationalisation and so on are quite compatible with mental health and can be abundantly exemplified and illustrated in everyday life and conduct. This is not the case with conversion, which must be regarded as a definitely abnormal reaction from the start.

Conversion is the process by means of which repressed ideas manifest themselves in consciousness, not attached to any object therein, nor in any form of mental activity at all, but as gross disorders of bodily function. The ideas, that is to say, are represented entirely in terms of body and not of mind. Conversion is thus conclusive and irrefutable proof of " psychosomatic unity," and the final convincing justification of all that has been said about " the language of symptoms." We have learned that ideas are consciously expressed and information conveyed in the psychological shorthand of bodily gestures. We have learned, too, that conscious emotion is accompanied by bodily changes. All this and much more now falls into place when we realise that *repressed* material, in certain circumstances, expresses itself in bodily changes far more inexplicable and dramatic than any we have yet mentioned. A flaccid paraplegia has already been referred to in passing. A complete paralysis of any limb or limbs, with or without accompanying analgesia, is very common. Aphonia, anorexia and torticollis are commoner still. Mutism, deafness, retention and incontinence are all quite frequently met with. Patches of anaesthesia, so profound that a surgical operation can easily be performed on the affected part, are by no means uncommon and a complete hemianaesthesia is so little of a rarity that one

might safely bet on finding at least one instance of it in any large hospital on any given day. The fine flower of conversion is perhaps the well-known " pseudocyesis " in which the signs and symptoms of pregnancy are successively presented, complete in every detail—except the presence of the foetus. The list might be extended almost indefinitely, but we may conclude this selection by mentioning the epileptiform seizures of all grades of severity which are well-known conversion symptoms.

Now all these disturbances of bodily function are the disguised and symbolised expression of repressed material which has succeeded in " dodging " repression and entering consciousness unrecognised by means of this remarkable process of conversion. The precise nature of the bodily disability is in every case intimately related to, and determined in its details by, the nature of the repressed material. It follows, therefore, that rational curative treatment demands and depends upon a knowledge of the personal mental conflicts of the individual patient concerned.

Further than this we cannot now go, and it is improbable that you will get very much further in your student days while the approach of general medicine to this question remains what it is.

It is hard to believe that any intelligent student who knew the essentials of " case-taking " and had the faintest glimmer of understanding of the human approach to his patient could really remain long in serious doubt as to whether a symptom was " functional " or " organic," save in the rarest and most difficult cases. " The books," however, take another view, and you will find yourselves faced in due course " for examination purposes " with lists of the features which distinguish " functional " paralyses or seizures or anaesthesiae from the " organic " conditions which they simulate, set out in parallel columns. These you must carefully learn, and with their aid you may eventually reach a correct conclusion, provided always that the word " simulate " has not misled you into the belief that " functional " symptoms are merely a cheap imitation of " the *real* thing." If it has, then you will start the wearisome and endless hunt for " the organic " with the conviction that if you can't find it you will have proved conclusively that there is " nothing really wrong " with the patient. The whole thing

is vaguely reminiscent of Lewis Carroll's immortal Bellman whose lecture on the unmistakable marks " distinguishing those that have feathers, and bite, from those that have whiskers, and scratch " was only terminated by one of his hearers fainting—presumably from exhaustion.

We have now concluded our discussion of the more theoretical rather than the directly clinical aspects of medical psychology, and but two things remain to be said.

The first is yet another assurance to all concerned that I entirely agree with anyone who says that " mental mechanisms " is an unsatisfactory expression. In fact I go all the way with Polonius and say " that's an ill phrase, a vile phrase." But it is a convenient and time-honoured phrase. I did my best to give it an explanatory introduction on its first appearance in these pages, and having given it this obituary notice as well, I did not feel it necessary to suspend it between inverted commata, like a malefactor hanged in chains, every time it appeared in the text.

The second is that the material in the last few chapters has been indeed inadequately presented if it has failed to make the student realise that medical psychology is a subject of fascinating interest with an importance and dignity all its own, and to suggest to him that an intelligent understanding of its principles might possibly prove the coping-stone of his medical education.

Chapter 8

THE HERD AND GUILT

While the foregoing chapters are fresh in the student's mind it will be convenient to give, in very rough outline, some account of that remarkable force called " herd tradition " or sometimes "herd instinct."

We have been discussing some of the difficulties which arise when the conscious mind rejects, or refuses to acknowledge, the promptings to action which arise from the unconscious. The conscious mind, as we have seen, acts in this way because the ideas which the unconscious presents to it are quite incompatible with the standards of behaviour which it has acquired. We have not yet, however, considered how the conscious mind became educated up to the standards and principles which it often holds so firmly and defends so fiercely. We may certainly have a shrewd suspicion that it was not merely as the result of education in the narrow scholastic sense of the word. It was not by any process of reasoning, learning or memorising that we arrived at some of our deepest convictions or, for that matter, at most of the habits and customs of our daily life.

Many of these are utterly illogical or senseless and can only be defended by the most fantastic rationalisations. How, then, did the conscious mind ever become so fastidious, so exclusive, so completely confident in its own judgment as to what is or is not expedient, necessary or permissible ?

The question can be most simply discussed by regarding the conscious mind as being subjected to an influence from without, every bit as powerful as that which the unconscious exerts on it from within. We may call these two influences respectively, the force of herd tradition and the force of instinct.

We start life with a working outfit of active, or potentially active, instincts which, after a few years of development, can be relied upon to prompt us to a reasonably satisfactory response to most of the situations in which we may be placed. The response, however, is satisfactory only from an entirely personal and selfish point of view. It must conduce to the individual's

immediate safety or comfort, and in expressing and gratifying themselves our instincts, as we have already seen, have no concern whatever with the welfare or the rights of others. The consequence of this is that it is impossible to act solely on the dictates of instinct for any appreciable time without seriously upsetting the entire community.

Now the community dislikes being upset, and has disliked it for a very long time. It realised many centuries ago that if organised society were not to perish from the earth some measures of self-defence would have to be taken against persons who followed the desires and devices of their own hearts—that is, who acted on instinct—in blatant disregard of all other considerations.

That was the beginning of the very wonderful story of the origin and development of a social sense, and of the organisation and growth of the incredibly powerful force called public opinion, or, as we have styled it, herd tradition.

Man asked for it so to speak, because he has an innate need for and love of the presence of others of his kind, so strong that in the opinion of many it is itself an instinct. Be that as it may, the tradition of the herd compels obedience with almost overwhelming force, and that obedience has produced a remarkable and almost despotic government of man by his fellows which is of great importance and interest.

Membership of a herd offers very great advantages to the individual. It satisfies his craving to be one of a crowd, rather than isolated, and it gives him the benefit of those numberless amenities which only combined effort can secure, such as safety, justice, organised transport, food, clothing and so on, down to such exotic products as department stores, afternoon bridge-parties and night clubs.

In return it demands from the individual an unquestioning obedience to its rule, an acknowledgment of the insignificance of the one compared with the many and a cheerful abandonment of personal independence of action and sometimes even of thought in many of the affairs of life. Its guiding principle is " the greatest good of the greatest number," and its slogan is " safety first."

Let us look at this matter to begin with quite apart from any question of the unconscious mind or of intrapsychic conflict,

and simply as between the individual and the herd—the effort of the individual to adapt himself to the society in and by which he lives.

The trump card of the herd is, of course, that in the long run the individual is absolutely dependent on it. Left entirely alone and debarred from communicating with his fellows or making use of their work, any one man would die of hunger or exposure long before he could kill or grow his food, clothe himself or build a house. Short of such a drastic experiment, we all know the unanalysable sense of discomfort and unhappiness experienced by any normal person cut off for any length of time from intercourse with his fellows, and the profound but equally unanalysable sense of satisfaction aroused by entering into congenial company. Once he has found such company the average person does his utmost to remain a member of it by speaking the words, thinking the thoughts and acquiring the manners and customs of the other members. This is both prudent and labour-saving. It ensures his continued membership of the herd, with all its attendant advantages, and it saves him the trouble of thinking for himself.

We put a guest or visitor at his ease by inviting him to become " one of us " for the evening. We say that So-and-So is " one of the lads," implying that there are others—and so there are, but it is sometimes quite difficult to distinguish them from one another. They differ in minor details of costume, as one star differeth from another in glory, but in general they wear the same sort of clothes, speak the same sort of slang, go to the same sort of places, share the same sort of outlook and use the same sort of thought-substitutes.

The dictates of fashion furnish an excellent illustration of the authority of the herd. Even in these uncritical days there are few people who could be induced to enter a fashionable restaurant wearing brown shoes with otherwise conventional evening dress, and any physician can easily lose both his practice and his reputation for sanity at one stroke by the simple process of strolling in the West End clad in " plus fours," a morning coat and a bowler hat.

The herd has one punishment only—namely, expulsion. In the case of savages or animals this usually means death. To us it means social death, which many people think to be even

more terrible. Certainly one can hardly imagine any more severe punishment than to be quietly but unmistakably dropped, ignored or "cut" by one's fellows—to become, in fact, "an outsider."

This is the herd's punishment for those who offend against it, and it is important to remember that the question whether the herd or the individual was in the right in any given instances does not arise at all. The herd punishes quite impartially those who leap ahead and those who lag behind, those who wander to the right hand, and those who stray to the left. The herd showed its displeasure on a long-ago occasion by treating in precisely the same way two who were too bad for it and one who was too good.

Now, of course, the herd can be defied. It can even be defied successfully, though it is indeed rarely that the success becomes evident before the rebel has been in his grave for a century or two. Some of the most striking instances of defiance of the herd which succeeded in the end are to be found in the stories of those great men and women who, for the sake of scientific truth, defied the iron conservatism and the utter impenetrability to new ideas which are among the herd's most terrible characteristics. Galileo, Jenner, Darwin, Pasteur and numberless others suffered ostracism and contempt rather than abandon the truth as they saw it, and similar lists could be made of those who have attempted to defy the herd tradition in every department of life and thought.

Some idea of the courage required to take up one's stand against the herd may be gained by reflecting on the pitiable state of distress into which we are cast by the conviction that, even in some trivial matter, we have said the wrong thing, laughed in the wrong place, acted unconventionally or, in short, done anything with twopence worth of originality or individuality about it.

It is of course quite true that there are those—mainly adolescents of both sexes—whose sole form of occupation and amusement appears to consist in defiance of the herd's tradition in such matters as clothing, coiffure, personal cleanliness and ordinary good manners. Their performances, however, are to be regarded as the minor idiosyncrasies of this or that little herdlet, rather than a true defiance of any established herd.

They are mercifully short-lived as a rule, and neither those who perpetrate them nor those who have to endure them are any the worse for them in the long run. They go by various picturesque names such as "New Forms in Art," "New Thought," "Youth and the New Era," "Bursting the bonds of Outworn Convention," and so on. Their age is exactly the same as that of human nature.

Complete and abject submission to one's herd, or rather to all the herds—social, political, professional and so on—of which one is a member, would certainly seem to be the royal road to a supremely quiet and comfortable life. We must be thankful, however, that such total submission is an impossibility because it could only produce a character of intense but amorphous respectability, so utterly devoid of personality and initiative as to be nothing more than a psychological jellyfish. We should therefore dismiss as unkind libels the commonly made suggestions that such submission has sometimes been achieved by army officers, civil servants and others.

Such unconditional surrender is impossible because we all belong to many different herds which are often at variance with one another, and by submitting to one we offend the others. But total surrender to any one herd is also a practical impossibility because the conscious mind is not only subjected to the authority of the herd from without, as it were, but also, as we have seen, to the influence of the instincts from within.

Now the remarkable fact which makes life such an extremely interesting business is simply that the two great compelling forces—obedience to our instincts on the one hand and to herd tradition on the other—almost always act in opposition to each other. We are all, as it were, in the grip of two enormous policemen who are pulling in opposite directions. The result of this psychological tug of war is that in practically every case the herd wins, hands down. The victory should perhaps be called apparent rather than real because the instincts usually get an adequate degree of expression and satisfaction sooner or later, by some of the roundabout methods we have already discussed. But on the face of it the herd scores a sweeping success almost every time and the individual retains his membership and its abundant advantages with unshaken prestige. To all appearance his instincts have not merely been regulated

or controlled; they have been whittled away almost to vanishing-point.

When it is a question of something which "just isn't done" by one's herd, such, for example, as taking the place of a woman or child in the boat to escape from a sinking ship, obedience to the herd law can become almost automatic. Drowning may be very unpleasant, but it is so definitely preferable to the social consequences of dishonourable survival that the instinct of self-preservation is very often completely stifled and overpowered without a struggle and sometimes even without conscious deliberation.

It is perhaps more instructive to consider the curious behaviour which herd tradition imposes upon, let us say, a young couple who have fallen in love with each other. The problem before them is to express and satisfy their sexual instincts without giving offence to the herd which has laid down the approved procedures. We need not follow them through the formalities and conventions of an engagement and the endless preparations and arrangements which culminate in the solemnisation of holy matrimony—preferably by the bishop—in one of the three or four "only possible" churches. It is not for a moment suggested that these procedures are in any way ridiculous or "wrong." On the contrary, quite apart from any intrinsic merit or value they may have at the present day, it is remarkable how many of our customs and conventions served some good psychological or social purpose at the time of their origin and have a most honourable ancestry of wisdom and commonsense. The point is simply that if we are going to satisfy our instincts and the herd at the same time we must be prepared to take a large number of rather roundabout steps very carefully, and watch them very closely.

The influence of herd tradition, in short, is abundantly evident in our manners, customs, tastes, political opinions, religious beliefs and detailed conduct of daily life. In becoming —as he must—a member of the herd, the individual can hardly help giving up some of his own psychological independence. His thoughts tend to become those of the herd, and it becomes very hard indeed for him to keep an open mind to new ideas which conflict with the traditions of the particular herd to which he belongs. The ideal at which to aim in this difficulty was

clearly set forth by Emerson long ago when he said that the truly great man was he who could preserve, in the midst of the crowd, with perfect sweetness, the independence of solitude. That is to say, one should strive to be a good " mixer," while remaining captain of one's own soul—and it is not easy. The two extremes—the ideal member of the herd and the complete individualist—are immortally caricatured in the duet by Bunthorne and Grosvenor in *Patience*.

It will not be necessary to discuss this matter of herd tradition more fully. This outline was required because some knowledge of the compelling power of the herd will help the student towards an intelligent understanding of—and sympathy with—a great deal of the irrational conduct of his patients and his fellows, which he would otherwise find inexplicable and infuriating. It will also help him in his consideration of one of the most common, most distressing and least understood of all symptoms, namely, a sense of guilt. Only a very brief mention of it is possible here.

It has already been pointed out that the herd's traditions and codes are not *directly* based on any ethical system or moral law, and that the question of " right " and " wrong " need not, and very often does not, arise in a conflict between the herd and the individual. It is thus of quite remarkable interest that when the herd applies its punishment of expulsion, even in some trivial matter with which morals have nothing whatever to do, the effect upon the transgressor is very often to produce in him an unreasonable sense of guilt, utterly out of proportion to the gravity of his offence. To suffer from an acute sense of guilt is probably to experience the most " devastating " of all psychological states on this side of insanity. A sense of fear or anxiety or inferiority can generally be at least lessened or held in check by some mechanism or other, but a sense of guilt is infinitely harder to deal with, and the consequences of repressing or rationalising it are peculiarly apt to show themselves as severe neurotic symptoms. Literature and history unite in telling us that a sense of guilt can cling to a man for life, colouring his thoughts, haunting his dreams and often driving him to suicide. The reasons for this sense of guilt and of its shattering effects need not concern us now. The matter is mentioned because vast numbers of patients have a sense of guilt, either conscious

or repressed, and an awareness of that possibility is often of incalculable aid in dealing with their aggressiveness, or touchiness or eccentricity. It explains, among other things, why a patient with a morbid fear of tuberculosis who has been " treated " by X-ray and sputum examinations does not always accept the glad tidings that the reports are negative with grateful relief, and go joyfully home " cured." But these are matters for later study. Meanwhile the student might care to amuse himself by trying to discover why a dog can have an infinitely greater sense of guilt than a cat, why discipline is so often called " oppressive " or " tyrannous," and why the old school tie and the plain red one go so badly together.

Much of the herd's authority is exercised by a process of suggestion, and we shall now go on to a general discussion of this large subject.

Chapter 9

SUGGESTION

Suggestion is usually defined as " a process of communication resulting in the acceptance with conviction of the communicated proposition in the absence of logically adequate grounds for its acceptance."

It is clear from this definition that suggestion must play an enormous part in our daily lives and must be at the very root of our personal and professional relationships, and indeed of all human intercourse. It is a therapeutic agent of enormous power, and its study is of particular importance to the medical student for that reason and also because it is universally invoked to " explain " everything in the symptoms of patients and their response to treatment which cannot be explained otherwise. The usual elementary teaching on the subject may be briefly summarised as follows.

Suggestibility is a normal human characteristic, and there are various factors which affect it. The most important of these are : organised knowledge of the subject regarding which suggestion is made, the nature of the idea suggested, the manner in which the suggestion is presented and, above all, the power or prestige with which the suggestee invests the suggester.

Instances of the use and power of suggestion in everyday life are infinite in number and variety. All advertisement depends upon suggestion and also illustrates the point that a picture has usually a much stronger suggestive effect than a mere statement of the fact or fiction which it illustrates. Many a man owes his conviction that his tobacco and tooth-paste are unquestionably " the best " more to the suggestive effect of clever advertising than to any process of logical reasoning or trial and error.

Suggestion need not come from without, but may be made by the individual to himself, so to speak. This " auto-suggestion," in which the proposition is both " communicated " and " accepted with conviction " by the same person is said by many to be really the essence of the whole process, while

suggestion from without (" hetero-suggestion ") is merely the stimulus which initiates it.

The part played by suggestion in medicine is tremendous. There is a pleasant and widely held belief that it can affect the unborn child, and it is certainly a most important factor in nursery therapeutics. The observant student will find numberless instances of its use and misuse in the out-patient department, and many a house physician makes his first practical acquaintance with its powers by the timely administration of a hypodermic injection of sterile water to a sleepless patient.

Two forms of suggestion are often described; namely, " verbal " and " affective " suggestion. Verbal suggestion is the communication to, and acceptance by, the patient of some specific idea or line of conduct, whereas affective suggestion is the communication of general ideas and attitudes of mind, such as cheerfulness, endurance, optimism, or their opposites, and is not necessarily conveyed by the spoken word at all. What it *is* conveyed by is a question which must be left for later discussion. Meanwhile the student may very profitably indulge in private consideration of the matter, though it is but fair to warn him that no satisfactory answer to the question has so far been offered.

Closely allied to suggestion is the process known as Persuasion, which is the presentation of an idea to another person, offering him at the same time what he will regard as logically adequate grounds for its acceptance. Persuasion is suggestion plus an appeal to the patient's reason and commonsense. Persuasion appears to the patient to put all its cards on the table and to prove to him that there is no reason why he should not get well and every reason why he should. Suggestion simply tells the patient that he is to get well—tells him, in fact, that he *is* well—because the doctor says so, and the doctor is always right.

The phrase " to get well," which has just been used, demands some explanation and prompts us to study the action of suggestion in a little more detail, though any explanation attempted at this stage is bound to deal only with one aspect of suggestion, and to be extremely inadequate at that. We may assume that in all disorders there are several causative factors at work, and that in many of them the final link in the chain

of causation on which the patient's symptoms depend, is a conviction of disability. This conviction of disability on the patient's part is, so to speak, the link of insertion in any given symptom. The patient is convinced of his inability to speak, to walk, to sleep, to control his sphincters and so on, as the case may be. It is this link in the chain which is attacked by suggestion. Once the chain is broken, no matter where, the symptom will of course disappear, nor can it return till the chain is repaired, but the point at which suggestion breaks the chain is said—with a large measure of truth—to be the very point at which the chain can most quickly and easily repair itself.

It is pointed out that the underlying links in the chain which produced the conviction of disability are still active and untouched, and that no permanent relief can be expected unless the chain be broken much further back, or indeed uprooted altogether at its link of origin in the depths of the patient's mind. This is the position taken up by the various schools of analytical psychotherapy and the matter cannot profitably be carried beyond this point.

Any study of suggestion naturally leads on to the subject of hypnotism, but for junior students, or at least in this particular book for them, nothing more than a brief summary of essentials is necessary.

Hypnotism is simply the putting of a person into what is called the hypnotic state. This is a state of fatigued attention, somnolence, dissociation, suspension in large measure of the judging, reasoning and critical powers and, therefore, very greatly increased suggestibility. Hypnotism thus puts the patient into a state in which the process of suggestion is greatly facilitated, though it has not in itself any direct therapeutic value. Its relation to suggestion is analogous to that which a general anaesthetic bears to a surgical operation.

The second important feature of the hypnotic state is that it facilitates the task of bringing back repressed and forgotten material to the patient's consciousness. Nowadays, however, drugs are more generally used for this purpose, and, in any case, a discussion of the matter is beyond the purpose of this book.

Now all the foregoing, expanded by lectures, illustrated by demonstrations and clarified by discussions, may fairly be said

to include all the teaching on the subject of suggestion that the student needs, or can expect to receive. The more advanced teaching would probably include an historical account of hypnotism, a description of the various ways of inducing hypnosis, a study of the phenomena of post-hypnotic suggestion and an " explanation " of the action of suggestion in psychotherapy. These are all very interesting and important matters, though the student should be warned here that the psychoanalytical explanation of suggestion is a quagmire of desperate pseudo-scientific floundering which he is advised to shun until he has had opportunity to add experience and specialised knowledge to his native commonsense. He may then venture upon it with safety, if he can find nothing better to do. Meanwhile he may find it more profitable to consider a few points which unfortunately are rarely mentioned in either elementary or advanced courses of instruction on the subject.

Suggestion is the strongest therapeutic weapon you will have at your own independent command for several years. No occasion is too trivial for its use, and it is hard to reach the limit of its possibilities. If you are to make effective use of it you must obviously have some idea of its powers and of the purpose for which you are employing it, unless you are content to adopt the attitude of the prosperous Victorian physician and his sadly numerous descendants, and take for your own their familiar slogan : " Psychology is all rubbish. It's just suggestion, and we all use suggestion unconsciously every day." Here (to use Stephen Paget's phrase), if guinea-pigs could talk, is the level of their conversation. To fire a loaded revolver with your eyes shut every day is a dangerous pastime, even if you have a poor opinion of gunpowder.

Suggestion, far from being always curative or helpful, may be intensely harmful. A sudden change of expression or an indiscreet remark ; a tactless joke or an over-anxious solicitude ; such things as these may have a suggestive effect powerful enough to change the whole course of a case for the worse. The " atmosphere " of the out-patient department, the length of time the patient has to wait therein and the conditions in which he does so, the demeanour of physician, almoner, student and nurse at the patient's all-important first interview with any or all of them ; all these things can have the most powerful

suggestive effect for good or ill, and it is by no means only of " functional " cases that this is true.

But we must have from the beginning a clear idea of what we expect suggestion to do. We are considering it in its relation to general medicine and we can say, in short, that we expect it to relieve symptoms but not to cure diseases. You will already have learned enough to realise that that is a crude way of expressing the point, and that the difference between a disease and a symptom is in many cases very far from clear, but the terms convey a definite enough impression and may be accepted at this stage without debate.

There are, of course, many symptoms which suggestion fails to relieve, and many to which it is obviously inapplicable. Nevertheless, suggestion is far more often neglected when it should be used than attempted in an unsuitable case, and the failures are far more often due to faults in the suggester's methods and in the nature of his suggestions than to the inherent inability of the patient to respond at all.

The ability to decide with confidence upon the suitability of a case for treatment by suggestion, and upon the best suggestion to give and the best way of giving it, will only come after study of the subject plus clinical experience. The junior student will not be called upon to make the decision or to attempt treatment by direct verbal suggestion at present. He cannot begin too soon, however, to educate his judgment in the matter, and the following paragraphs contain various small pieces of information and advice which may be of use to him both now and later.

Suggestion, like most of medicine, originated in magic. It is not necessarily any the worse for that, but unfortunately it still shows the traces of its ancestry rather too obviously to allow it to mix comfortably with other phenomena which science has explained and, so to speak, legitimatised. You can say what you like about a thunderstorm, for example, so long as you call it " electrical disturbances in the atmosphere," but if, with its family tree in mind, you refer to " Thor," you will be regarded with suspicion and may find yourself ostracised as a dangerous dabbler in the occult. It is important, therefore, that you should do what you can to assist science to whitewash suggestion, especially as, so far, she has made an exceedingly

poor job of it. But even if she should get no further than inventing one or two new descriptive words, you must help by clearing away as well as you can any remains of mystery or magic hanging around the subject which you may come across. Whatever suggestion may be it is not magic, and you must cleanse it of anything which might tend to make ignorant people think it is. That is to say, you must never " play to the gallery," never imagine that it is remarkably clever to " cure " people by suggestion and never give—or attempt to give—the impression that you can hypnotise people by virtue of some mysterious and commanding power which you possess.

This is not easy, and the difficulty is increased by the fact that self-confidence is an essential for the successful teaching or practice of suggestion, and the more implicit the patient's belief in the physician's ability to help him, the better and more rapid is the result likely to be.

But self-confidence should be tempered by remembering that a suggestion which fails is worse than no suggestion at all. Many a dramatic result has been achieved by telling a patient that his symptom will have vanished in five minutes, but until one is very sure of one's ground it is wiser and safer to tell him that when he calls tomorrow he will be feeling much better.

Any suggestion made to a patient must be reinforced by every means in one's power, and everything that might act as a counter-suggestion should be eliminated. A case of nervous vomiting cannot be successfully treated by suggestion or persuasion while a large basin issues its silent but sinister invitation from the bedside table.

Suggestion is not an impersonal routine procedure such as administering a dose of medicine or a hypodermic injection, and very many failures are directly traceable to neglect of this truth. It is courting disaster to attempt treatment by suggestion without first giving careful thought in every case to the best method of setting about it.

Most suggestions can be presented in a great variety of ways. They may be made directly or indirectly, once or repeatedly, persuasively or commandingly. The idea to be suggested may be put forward as an abstract proposition or crystallised in the form of an example or practical demonstration. The ideal form for the suggestion to take depends on the patient, the

physician, the exact purpose the latter has in mind, and the relationship between the two persons. This leads us to the consideration of " affective " suggestion, which it is impossible to separate completely from verbal suggestion, and which is much the more important for the junior student to study. He can use it—indeed, he can hardly help using it—every day. Like the Victorian physician already mentioned, he will also use it unconsciously all his life, and that very fact makes it all the more important that—unlike the Victorian physician—he should train himself to make an enlightened and intelligent use of it. Over-anxiety as to the result of a *verbal* suggestion will at once communicate itself to the patient by a process of *affective* suggestion, and the verbal suggestion may consequently fail. An uncertain or timid manner will by the same process cause the patient to feel (" with conviction") that you are not a person he can trust, and his resistance to your verbal suggestion will be enormously increased. An overbearing manner, by the resentment it produces, will have a similar disastrous effect upon the patient's suggestibility. Other illustrations have been given earlier in this chapter, and many more will occur to the student as a result of his daily experiences in hospital life.

The main point to grasp is that, whatever its relation to verbal suggestion may be, affective suggestion has a most powerful influence on a patient's state of mind on its own merits, so to speak. It will certainly be a factor in making the patient either more or less amenable to verbal suggestion when the latter is being used, but, used alone, it is a most potent therapeutic agent in nervous and mental disorders and an invaluable aid in all forms of medical and surgical treatment.

Some time ago I heard a surgeon say to the relatives of a patient on whom he had performed a serious major operation : " It all depends now on whether he has the will to live." He had operated, however, without satisfying himself on the point, which he had left to those who might consider it their business.

The " will to live " to which he rightly attached such importance is not an unchangeable characteristic such as the colour of one's eyes or the shape of one's ears ; on the contrary, it is an attitude of mind which is subject to great variation. Affective suggestion can usually do far more than any other

means either to strengthen the will to live enormously, or to reduce it almost to vanishing-point.

Children being much more suggestible than adults, a children's ward is an ideal place for practising affective suggestion and observing its possibilities. I have seen such a ward turned into a howling pandemonium in a couple of minutes simply because a house-physician, dressed in a short white coat and a little brief authority, was " too busy " to speak one single word to the small girl from whose ear he wished to obtain a drop of blood for a " count." I may add that to see a Sister who really knows how, restore a scene of this description to one of cheerful calm under one's bewildered eyes is an unforgettable educative experience which almost persuades one that suggestion really does work by magic after all. No mere man can hope to emulate the feat and no text-book attempts to explain it. One could hardly expect a text-book to discuss such things or to mention, for example, that there are occasions when the general practitioner finds his knowledge of a few simple tricks and puzzles more helpful to him in treating his child patients than his knowledge of the latest volume on pediatrics.

The " bedside manner " has been the subject of so many jests and gibes that one hardly likes to use the phrase. For this we have to blame the insincere bombast of the " How are we today " school. I think our Victorian physician was of that school and that the remark represents one of his efforts to use suggestion consciously. He forgot—as do his descendants and imitators—that the one fatal thing for affective suggestion to do is to draw attention to itself and its object. If the cheerful manner is anything of a misfit, or if the laugh betrays the underlying effort or lack of spontaneity, the patient will most certainly see through the proceeding and through the physician. He will be silently resentful and perhaps contemptuous, or he may pass polite but humiliating judgment by saying : " I understand, Doctor—you are just trying to cheer me up." Thus his last state will be worse than his first.

To get the matter clear we must come back to that unfortunate phrase about employing suggestion " unconsciously." In a sense it is quite correct, but the word is not adequate. We convey affective suggestion " automatically "—using that word in its psychological sense. An " automatic " act is an act

which is in no sense instinctive and has to be learned—often with much difficulty—to begin with. Constant training and repetition, however, make it so familiar and habitual that we become able to perform it " without thinking about it," and we devote no effort and very little conscious purpose or attention to its performance. Finally it becomes " second nature " to us and is performed as an automatic response to the appropriate stimulus, requiring the very minimum of our conscious attention. Of such are our routine actions in dressing, shaving, using a knife and fork, etc., as also are the minor social and domestic courtesies and habits of daily life. An extreme instance of the type of automatic action we are discussing is that of the expert pianist who, while playing a familiar piece of music with good technique and expression, can conduct a conversation on an unrelated subject with a bystander.

We need not pursue this matter further and enter on the discussion of conditioned reflexes and dissociated states to which it points. Enough has been said to make it clear that affective suggestion can only be conveyed by means which come naturally to the suggester, and that many of the characteristics and abilities which are popularly said to come naturally do nothing of the sort, and are only acquired after prolonged effort and patient training and development of such " natural " possibilities as one does possess.

The " bedside manner " may be taken as meaning something or some combination of things in the physician's appearance, manner, voice, conversation and behaviour which have the effect of making the patient " feel better for the very sight of him." This happy result is achieved by affective suggestion and, as we have just seen, it will inevitably be ruined not only by conscious insincerity on the physician's part but by anything in the least degree forced or unnatural about him. It is easy to tell whether a piece of music performed with perfect correctness has been played by someone familiar with it or by someone who has just succeeded in mastering it. The painstaking accuracy with which a person will carry out the details of some social convention to which he happens not to be accustomed is often enough to attract the concentrated attention of a roomful of strangers. Still more surely will the acting of a part by the physician be detected and disliked by the patient.

Unless, therefore, we are entirely satisfied with our native equipment we must clearly decide as soon as possible what additional, or perhaps counteracting, qualities are most likely to be helpful to us in dealing with our patients—which is to say, in dealing with our fellow creatures—by affective suggestion. We must then proceed to absorb them so thoroughly and practise them so habitually that they become " part of ourselves." What these qualities may be, or what would happen if we could make them our own, are questions which each student must tackle for himself. You may hear something about a few —surprisingly few—of them during your medical curriculum. You will discover many more for yourself from personal experience of medicine and of life. You acquired some of them, perhaps, at school, but I think that if you were lucky you absorbed some essential ones, which are already becoming " automatic," at an earlier stage than that. If so, I should advise you to bank on those from the start, because whatever they lack they are your own, and nothing is any use till it becomes that.

Some years ago I spent an instructive forty-five minutes with a small girl whose mother was " upstairs, putting on her hat." I tried to entertain her with some very poor attempts at mimicry, at each of which she smiled dutifully. When invention failed I asked, with a rather forced gaiety : " Whom shall I imitate next ? Who shall I be now ? " to receive the reply, spoken in all innocence : " Be yourself."

You will observe that our discussion of affective suggestion has travelled—not drifted—to the question of personal character.

What these two have to do with each other and with " general medicine " are matters which must be left to your private consideration. I shall content myself with merely passing on the salutary piece of advice just quoted.

Chapter 10

INFERIORITY

Let us suppose that someone has a very deep-seated conviction that he is unable to make adequate response to the demands of life, that he cannot deal satisfactorily with its problems, that he is not, and can never be, as successful as his fellows, and that life is in fact a race in which he has not the slightest chance of making even a decent show, let alone winning a prize.

We shall put aside for the moment the question of how this conviction arose, and merely discuss its effect upon its unfortunate possessor.

The first important thing to note is that it is of no consequence whatever whether the conviction is justified by the facts or not, in any given case. If a person holds such a conviction, then it is true for him, and no amount of argument will have any effect upon it. It was not reached by any reasoning process, and it will not be removed even by logical proof of its falsity. This is just one more instance of the difference between knowledge based on feeling and knowledge which is a reasoned conclusion from premises or data. The matter was dealt with at length in our discussion of rationalisation—that universal tendency to explain feeling in terms of reason.

The next thing to note about this conviction of inadequacy is that it is, literally, intolerable. It cannot be endured for any length of time and, in self-defence as it were, its possessor does his utmost to stifle it and to convince himself that it does not exist in him. He attempts, that is to say, to alter his feelings about life, and to do this he requires to use the time and the energy which should be occupied in getting on with life and facing its problems regardless of what he may feel about his inadequacy to the task.

Instead of struggling to adapt himself to life, he is in fact trying to make life look as if it were adapting itself to him. It is as if he were at the foot of a huge and forbidding cliff or mountain, up which he must sooner or later attempt to climb. He cannot run away from it altogether, but so much as a look

at it is enough to make him collapse with fear. What is he to do?

If he were capable of going " bald-headed " at the mountain, and starting to climb, his feelings about the impossibility of the task would soon cease to trouble him and all would be well. That is the response of courage and health. If, on the other hand, he were to succeed in turning his back on it completely and running away, it would be upon the road that leads to psychological, and often physical, suicide. That is the response of cowardice and psychosis. The third course open to him is the one I have imagined him as taking. He dodges about with life's problems, " backing and filling " and changing his mind, with all his energies devoted not to finding an honest solution of them, but to making them appear less alarming. That is the wobbling response of the neurotic, and it is the one which in varying degrees we are all more or less prone to adopt.

We may regard this imaginary person as spending his time in trying on different pairs of glasses of every kind in the desperate hope of finding a pair which will make the mountain look so small and so easy to climb that he can contemplate it with comparative equanimity. Now it is quite possible that, in a sense, he may succeed in this effort. We can imagine him finding a pair of lenses so cleverly contrived that the mountain appears a mere knoll. Unfortunately, this apparent success does not help matters in the least. Sooner or later he will have to drop the glasses for rest or refreshment, and the moment he does so there is the mountain as grim and forbidding as ever, and there is he, not one poor inch nearer to it. His efforts have all been on the wrong side of life, so to speak, and the real task still remains to be tackled.

The dodges and devices by which such a person avoids frank contact with life form, in well-established cases, an easily recognisable neurotic character. As I have said, however, we all resort to them in varying degrees from time to time, and it should not be difficult for you to find illustrations of those I am about to mention in the everyday conduct of your patients, your fellow-students and everyone except yourself. Should you wish to be convinced that you are not really an exception you must ask some candid friend.

We may make a very useful, if somewhat artificial classification of the problems life presents to us by grouping them under the three heads of occupational, social and sexual. We may thus regard the mountain as having these three separate peaks, all of which must be scaled.

Now the obvious thing about occupational, social and sexual problems is that none of them can be satisfactorily solved alone. A man on a desert island need not worry about choosing a career ; there are several people in any club or team or union ; it takes at least two to make a satisfactory love affair. The hillside, then, is seen to be covered with groups and companies of never less than two people and usually many more, making their way up to the peaks with apparent ease and cheerfulness, and inviting strangers to join the glad throng. Now this is the very thing which our imaginary climber, whom we had better call Mr. X, cannot do. To form human contacts is the thing which reminds him more than anything else of what he is spending his whole time trying to crush down and forget, namely, his sense of inadequacy and inferiority. It is the tendency of Mr. X, and all like him, to withdraw as far as they can and as often as they can from every contact with their fellows. I need hardly point out that he is not aware of his reason for doing so, and you will not have far to look for instances of rationalisations by which almost everyone justifies this tendency to himself from time to time, as for example in some of the elaborate reasons we offer for declining invitations to various social functions.

No ordinary man, however, can avoid social contacts altogether, and therefore Mr. X is bound to do his best with them from time to time. His best consists, and can only consist, in being on the defensive from the outset. His one object in every new contact is to boost his self-esteem and satisfy himself that he can hold his own in any company. His thought, if it could be clarified and made conscious, would be something like this : " Here is Mr. Z, of whom everyone thinks such a lot. Well, I don't care. I will show him that I am as good as he is, and if by any chance I can score off him and let him see that I am not going to be patronised by anybody, that will prove me better than he is, and if I am better than he is there is nothing for me to worry about." Thus every new acquaintance is

regarded as a potential competitor and rival rather than as a potential colleague and friend, and life becomes not an exercise in co-operation but an essay in competition.

It is quite certain that this will be the fundamental attitude of a great many of the patients whom you meet for the first time, and it will be obvious that unless you are forewarned of the possibility, your attempts to get accurate information and a co-operative attitude from them may be unsuccessful.

But Mr. X has many other cards to play. The easiest way of maintaining a good opinion of oneself is, of course, to hold a low opinion of those around one, so Mr. X becomes a devastatingly destructive critic of others. He cannot help it. It is to be noted too that it is a matter of psychological life and death for him, and that he is putting all his energies into the job, so that if he is endowed with ordinary wits and intelligence he can make himself an almost incredibly unpopular member of society in record time. He aids the process himself by constantly dwelling upon his own merits, and he soon earns the reputation, as all destructive critics tend to do, of being exceedingly conceited. He does not always deserve this, and the more one understands him the sorrier for him one feels.

I once suggested to a patient of this kind that he was perhaps making a little too much of his position in a large business firm, the directors of which, he had led me to believe, hung upon his every word and were helpless without his guidance and advice. He turned on me and in tones of ineffable scorn, made the remarkable retort : " On the contrary, Doctor, I do not think myself half so important as I really am."

The truth of the matter is that Mr. X simply cannot be one of the crowd. If he cannot be quite certain of being exceptional in some way or other he will not play at all, or if he is forced to do so he will be something of a nuisance to himself and everybody else. I am sure that most of us know many people of this kind.

I once asked a patient why he had never played football when at school, and received the pathetic answer : " Lest I should fail to score goals." If he had played he would have played better than some and not so well as others, nobody would have bothered much, and a good game would have been had by all. That, however, would have been no

use to him. If he could have had a guarantee that he would be a star performer, or would save the side at a critical moment, he would have gone through fire and water to play and would have put every scrap of energy and skill he possessed into the game. But to risk being an ordinary undistinguished member of a team was too dangerous.

Half a dozen youths go in, let us say, for an examination in which the top marks are 100. Two get 63, three get 68 and one bright performer gets 74. These are all quite decent marks out of 100, and the normal procedure is to meet in some place of public refreshment for a friendly talk about the matter and to drink the health of the top scorer at his own expense. Mr. X would adopt, if he could, an entirely different procedure. He would, at all costs, avoid sitting the examination, and would measure the performances of the others against a private marking scheme of his own, the top marks being 250. Even 74 is a lamentable score out of 250, and Mr. X would point this out with great force, at the same time skilfully implying that if he had been able to compete, or had cared to compete, a wondering public might have seen something really worth while.

I saw this beautifully illustrated by two middle-aged gentlemen whose football days were long over, who were pouring a flood of caustic criticism on a schoolboys' match which they were watching. The implication was that football was not either taught or played as it used to be, and that, even still, these two old stagers could show how it should be done. The fact was that their envy of the youth and energy of the boys and their regret that they themselves were "back numbers" were so keen that they had to be smothered and forgotten at any cost.

I was badly beaten at lawn tennis many years ago by a Divinity student of whose prowess at the game I had formed and expressed the lowest opinion and, to ease the sting of defeat, I remarked to him in the most friendly way possible as we walked off the court together: "Anyhow, I know a lot more about psychological medicine than you do." This was perfectly true but painfully and childishly irrelevant.

The simplest way to keep a bogy from popping up is to put weights on the lid of the containing box, and the exaggeration of the opposite qualities to those which he fears will be revealed

to himself and others is the constant occupation, or rather pre-occupation, of Mr. X and those like unto him. They are aggressively hearty, confident, opinionated, jovial and humorous, with a forced and artificial air about it all which is easy to recognise and painful to experience. In mild cases the victim is more or less conscious of his antics and of the reason for them. A young man bursts like a tornado into a smoking room, or mess room or club, greets people in a loud voice, offers cigarettes and drinks all round to people who merely want to be left in peace to read the paper, asks them to make up fours at bridge, to have a game of billiards and so forth. When he leaves, the room seems less crowded and someone remarks that he was something of an infliction. But another may perhaps say: "I think that it is really only his nervousness." The fact of the matter may well have been that the youth stood outside the door literally sweating with anxiety and forced himself to go in, knowing that he would be gauche and unnatural, ill at ease with everyone, wrong in his words and wrong in his silences. Men have won the Victoria Cross for less.

It must be remembered that this is not the same thing by any means as "whistling to keep one's courage up." The small boy, for example, who comes to you with a message through a dark country lane where somebody was murdered last week, will tell you that he felt pretty afraid but just whistled a tune and got on with it. That is very engaging and pleasant. The boy has done his best to fortify himself against a real danger and you congratulate him on his pluck. But if you meet the same boy going along the king's highway in bright daylight, not only whistling but having commandeered the town brass band to assist him with his music, you are right to wonder whether this remarkable display of carefree confidence may not be concealing a deep and unadmitted fear.

Several years ago in the film version of a nursery story, the Three Little Pigs danced hand in hand while singing their slogan "Who's afraid of the Big Bad Wolf?" This was not a merely rhetorical question as many people seem to think. *They* were afraid of the Big Bad Wolf, very greatly afraid; hence the bravado. If the average adult citizen meets a policeman he passes him without experiencing any undue emotion and proceeds on his business. But a small boy who has

every reason to be afraid of the policeman can be imagined as crawling past him, making himself as insignificant as he possibly can until, when he gains security behind the railings through which the policeman cannot squeeze, he dances his war dance and shouts obscene defiance, thus restoring his morale and rehabilitating himself in his own esteem.

Now it is clear that anyone whose life work consists in keeping up his own self-esteem against all comers will be unduly sensitive to criticism, and this is so to an almost incredible degree in the case of such as the unfortunate Mr. X. The slightest breath of what the ordinary person would call fair comment is regarded by him as damaging, malicious and unwarranted criticism, and he resents it with his whole soul. He cannot afford, you see, to make a mistake. If he once admitted to such a thing he would fall off his psychological tightrope and that would be the end of him. His one hope is to keep convincing himself that he could do everything just 10 per cent. better than anybody else. One of the saddest things about him is that not even over the ordinary little slips, errors and lapses of everyday can he say " I'm sorry : my fault," and go on again cheerfully like the rest of us. Once he has to realise in any relation of life that he is not really a superman but just one of the bunch, he goes to the other extreme and grovels abjectly, overwhelmed by a sense of hopeless failure. That *he* should forget an appointment, make an error in spelling, have a headache, make a slip in the accounts, lose a game, speak unkindly in haste and so forth, is irrefutable evidence that, as he feared all along, life is just a hopeless mess and he is one of the most wretched, frustrated and badly treated of God's creatures. This kind of reaction extends into what we may call a psychological " agony rule." When all devices fail to conceal from Mr. X the unscalable height of the mountain, when the paralysing consciousness of his own ineptitude is about to burst upon him with irresistible force, he has one last resort—he doubles the height of the mountain, halves the size of himself, reduces the situation to a palpable absurdity and indulges in an orgy of self-pity. This is known as the " poor little me " stunt and is almost always worked with a striking display of emotion. " Yes," says Mr. X, with shaking voice and not unmanly tears, " it is all very well for you. You had kind

parents and enough money and a decent education and good friends. But when I think of what I have had to fight against, when I think of my struggles, my difficulties, my misfortunes and, I fully admit, my weaknesses, I sometimes wonder not why I have done as well as I have, but how I have lived through it at all." This is very comforting.

A classical illustration of the reaction is to be found in the case of the prophet Elijah who said in the unmistakable accents of Mr. X: "I, even I only, am left; and they seek my life to take it away." I may digress for a moment to point out that the answer received by the prophet illustrates one quite satisfactory line of treatment, namely, getting the patient to see that he is not the only pebble on the beach. Elijah was told, in effect, that there were seven thousand others doing the same work as himself and making a great deal less fuss about it.

We are not going to discuss the origins of this sense of inferiority, but it is easy to see that it is very likely to date from childhood and that the kind of inferiority of which children are first and most painfully aware is a physical one. A small boy who cannot play football because of a paralysed leg will feel his disability infinitely more keenly than a boy who fails to master the elements of Latin or French, and will be regarded by his fellows as much the more abnormal of the two. Such physical disability is, in fact, very often the starting-point of a deep sense of inferiority, and when this is so some very interesting results in character and conduct are observable. It is simple fact that the majority of busy, active, fussy, aggressive, opinionated men with a passion for "organising," seem to be below middle height. A big man may be clumsy but is proverbially capable of great gentleness, and one imagines that some men of small stature entering, let us say, a crowded meeting or ballroom, experience in the vaguest possible way a feeling that they must do something to ensure that their presence is felt, and to satisfy themselves that all is well, that they are not being overlooked and that they are really in the party. What they do is very right and necessary and is usually very well done. There are windows to be opened, or extra chairs to be brought in, or a vote of thanks to our worthy secretary to be proposed, or an announcement made that tea will be served in ten minutes in the hall downstairs. But more often than not it is the under-

sized man who does these things and they bring great contentment to his mind though he knows not why.

The New Testament story of Zacchaeus the tax-collector, who I think must have been the original Mr. X, illustrates this type of inferiority sense with amazing accuracy. His choice of occupation was gloriously characteristic. Despised by the Roman conquerors and loathed by his own compatriots, he nevertheless compensated perfectly for his physical inadequacy by exerting a savage and unjust authority over his fellows with the full support of Rome behind him. The craving to get above his colleagues both metaphorically and literally is delightfully shown in the incident of his climbing the tree to see the great teacher pass, and his conduct, after cure by a psychotherapy still far beyond the present comprehension of our slow science, was admirably appropriate. He re-established his human contacts by giving a party and announcing at it that all grievances were to be adjusted and old scores wiped off and that he would henceforth be one of the crowd.

One more device to which Mr. X is apt to resort is the use of phantasy—a mechanism which we considered at length in an earlier chapter. We rarely find him dealing with an inferiority sense by the drastic method of turning aside from the prospect of the mountain altogether and entering once for all into a dream world of his own, but he has a strong predilection for halts at roadside houses where the entertainment is calculated to make him forget the facts of the situation and become reluctant to return to them. Thus " wishful thinkers " are made.

Such " thinking " is best observed in children, as we have seen, and is often very evident, as one would expect, in their dreams. A weakly, undersized youth called Paul was an undistinguished member of a very unsatisfactory school. He had an undescended testicle and when this disability unfortunately became known, the child's life, already made wretched enough by " ragging " and mild bullying, was rendered a positive agony by the ribald jests of his fellows. He had but one way of escape, and, almost every night, he entered the world of phantasy and " got his own back " by the following constantly repeated dream. He was sitting on a golden throne, clad in robes of oriental splendour, at the top of a flight of

marble stairs. Crawling up the stairs to his feet came first the headmaster, then his form master, and finally his classmates and his chief tormentors among his fellow pupils. As each in turn bent low to do obeisance to him, he spurned them with his foot, and by a deft sideways movement, kicked them one by one over the edge of the steps into an abyss of smoke and flames beneath. He had to return every morning to pitiless reality but he had had his hour, and I think that very probably the dream helped to avert a complete mental breakdown.

You have been listening to a talk on what is popularly termed " inferiority complex." Since the public got the phrase " split mind " to play with, we have perhaps heard a little less about inferiority complex from our patients, but the words still remain one of the minor horrors of the consulting room. There is nothing wrong with the expression in itself. At least it means something, which is more than can be said for many of the expressions used by our patients and ourselves. The trouble is that it is so constantly and foolishly misused, particularly in two quite different ways. Firstly, patients persist in regarding it as something which they have " got,"—as they might " get " an ingrowing toe-nail or a septic finger, and announce expectantly that they have come to you to have it removed. In the second place the phrase is used in truly maddening fashion as a kind of general utility explanation of almost every symptom or disorder known to psychological medicine, from nocturnal enuresis to paranoid schizophrenia. Parents are specially prone to " explain " every possible vagary of their offspring in this way and, as the phrase is regarded as respectable and sounds quite " scientific," many physicians thankfully accept it, and agree with the amateur diagnosis lest worse things befall them.

The world is full of people who are perfectly " well," " sane," " normal," " balanced," or anything you care to call them, who, nevertheless, seem to be repeatedly having spots of bother with their families or employers, or friends, or servants, or colleagues, or doctors, or lawyers, or clergymen, or with life in general. It is quite true that every individual has his own characteristics, and that it is just a question of getting on with people. Some are easier to get on with than others : there must be give and take on both sides. Yes, but not continual

" give " on one side and continual " take " on the other. People have bad luck and are unfairly treated from time to time, and in most quarrels there is no doubt something to be said on both sides, but if a man resigns from, say, six successive jobs because he considers the conditions of work intolerable, one may be forgiven for wondering whether the man's outlook on life may not be more unsatisfactory than the conditions of his employment. Of course there are numberless little characteristics and touchinesses and temperamental difficulties which are apparently very superficial and of which we all have our share. " A little tact " is all that is needed—and that is the very point. You may call these things superficial if you wish, but, as I have been trying to show you, they are all outward and visible signs of inward and psychological difficulty and maladjustment, of varying kinds and degrees. They are not illnesses ; you are up against them fifty times a day, and however large your share of native tact may be surely your chances of successfully dealing with them will be immensely increased if you have some understanding of their true nature and the roots from which they spring.

It is no use to talk about the importance of the psychological approach to medicine and then to ignore or belittle the importance of the details of the approach to an individual patient as trifles, just requiring ordinary tact. These trifles are the essence of the art of medicine, and your " ordinary tact " will lead the way to successful treatment just in proportion as it is an intelligent, informed and developed tact, based on an understanding of the psychological principles underlying our common human nature.

For example, it is no doubt a very trifling and superficial thing to advise you to greet a neurotic schoolboy with a cheerful " Hullo " rather than a formal " Good morning " when he enters your consulting room. It has nothing to do with scientific medicine, nor will you find it mentioned in your textbooks. You may say that everyone knows that sort of thing. If so, it is surprising that so few practise it, and that still fewer realise that it may make all the difference to the responsiveness of the patient on which your hope of helping him so largely depends.

And of course it is not only, or even mainly, to neurotic

patients that these things apply. I have seen a children's ward turned into a bear garden by a self-important house physician. I have seen children endure much discomfort and even severe pain without a word, because the doctor had earned their complete confidence. I have again and again been told by some sulky man or embarrassed woman, after unearthing some essential point in the history : " No, I didn't tell him ; I wasn't going to tell him ; you couldn't talk to that man." (Remember, please, that the fact that this is grossly unfair and untrue when said of you—though of course you can think of others to whom it might apply—does not matter in the least. If the patient feels it to be so, it *is* so for him, as we have already seen.)

The point of the whole matter is that this conception of a deep-seated inferiority sense and a patient's efforts to keep it from coming to the surface, which we have been discussing, explains and illuminates better than anything else, a distinct majority of the fads and resentments and unreasonableness which the ordinary run of everyday medical and surgical patients present in such endless variety. They have all—or almost all—a good deal of Mr. X in them, and the more you study that gentleman and his little ways, the better will you understand your patients, and the more likely will it be that you may come to be regarded by them as a man and a brother. And then only can you begin treatment with some hope of success.

Chapter 11

ANXIETY

"When I was a child, I spake as a child, I understood as a child, I thought as a child, but when I became a man I put away childish things." Did I, indeed? During adolescence some very remarkable things happened to me. I grew up in body, because I couldn't help it. Quite independently of my own views and wishes, or those of anybody else, I found myself, in due course, in a functioning adult body.

I also grew up in brain, which can be regarded as simply an organ of body. Here again it was not in my power or anyone else's to hasten or delay this process or indeed materially to affect it in any way. Nothing but the most violent and purposeful interference could have prevented my abilities developing, my range of experiences widening, my memory improving and so on.

But I did not necessarily grow up in a third way, infinitely more important than the two mentioned—namely, in my way of looking at things; in outlook. I did not, I say, necessarily grow up in outlook, because development of outlook, unlike that of body and brain, can be delayed or twisted or otherwise upset by a multitude of causes, among which early upbringing and home "atmosphere" are infinitely the most important. It is the exception rather than the rule for anyone to emerge from adolescence with body, brain and outlook all developed to an equal degree. Much more frequently an individual is pitchforked into adult life looking the part in body, able to sustain the part in brain, but pitifully inadequate to the part in outlook. He is thus at a very grave disadvantage in dealing with the occupational, social and sexual problems of adult life because he is looking at them with childish eyes. The situation is analogous to that of some presbyopic person attempting to thread a needle without putting on his glasses. His understanding of the problem before him is complete, and his efforts to solve it are as earnest and sincere as could possibly be desired. They will be fruitless, however, not because he

is not trying hard enough, but because he has not got his problem in proper focus. The moment he adjusts his outlook upon it by putting on his glasses, and not till then, his efforts will have some chance of success.

It is clear that if an individual has a childish outlook on adult problems and situations, his adjustment to them is unlikely to be satisfactory whatever the excellence of his physical or intellectual equipment. It is equally clear that such unsatisfactory adjustment will prevent a free and healthy outflow of his energies along occupational, social and sexual channels.

We must digress here to point out that maladjustment with consequent lack of outlet is not always entirely due to the undeveloped outlook referred to. It may also be due to unfavourable outside circumstances. A man on a desert island will be deprived of outlet for his social instincts and energies for the excellent reason that there is no society available to which he can attempt to adjust himself. On the other hand, a man will be equally deprived of social outlet, though he live in a fashionable centre and be swamped by invitations to social functions of every kind, if he happens to be so inherently shy that he is unable to take advantage of the social opportunities with which he is surrounded.

As a matter of fact, both factors are operative in most cases, but some central fault or childishness of outlook is the more common and the more important of the two. A man with a developed and adjusted outlook can withstand almost incredibly adverse circumstances, but the less well adjusted he is the more seriously will he be affected by even slightly unfavourable conditions. If you have your feet firmly planted on the pavement you can stand a good deal of jostling from passers-by without difficulty, but if you are walking on a tightrope even a gust of wind may come near upsetting your balance.

This distinction is not of immediate importance to the student but will become so in his later studies as it is concerned with the division of anxiety states into two great groups with differing symptoms and treatment. Another reason for its mention here is that it raises the general question which crops up so constantly in medicine : are we to adjust the patient to suit his surroundings, or the surroundings to suit the patient? Both are almost always necessary of course, but the error into

which the present-day student is most likely to fall is that of devoting attention to matters connected with the patient's environment and taking for granted that once this has been made reasonably satisfactory the patient will have no difficulty in adapting himself to it. This error is merely an instance of the age-old fallacy on which endless schemes of social reform have been, and are being, based, thus ensuring their own ultimate collapse. It is important to avoid it when considering this question of anxiety because there are always *some* unfavourable factors in the patient's environment and he will certainly tend to make the very most of these rather than admit that his own inherent inability to adapt himself to circumstances could have anything to do with the matter.

We may now return to consider this question of lack of outlet, however caused. Let us imagine a large reservoir, fed by springs in its depths, which discharges its contents along three great channels to places where they will be of use, and at a pace which is regulated to maintain a constant level of water. If these outlets become partially or wholly blocked so that the water cannot pass through them in sufficient quantity the result will be a rising in the level of the water in the reservoir until it overflows and wastes itself in flooding the surrounding country. The maladjustment here, however it may have originated, has immediately resulted in lack of adequate outlet, and it is to that lack of outlet that the overflow and flooding are directly due.

To take a simpler illustration still, if a pistol bullet is fired against an armour-plate which it cannot penetrate, it can only expend its energy—as of course it must do somehow or other—in the production of sound, heat and so on.

The overflowing water from the reservoir, and the sound, light and heat of the obstructed bullet, are wasted and misspent energy due to lack of satisfactory outlet. A parallel process occurs in every human being whenever the pistol-bullet of desire, with all the energy of instinct behind it, comes up against the armour-plate of prohibition or insuperable difficulty or fear. The resulting evidences of wasted energy are called "anxiety symptoms."

Anxiety is essentially a compound, resulting from the clash of the two great opposites, desire and fear. Ernest Jones has

pointed out that we use the word " anxious " in popular every-day speech to indicate either of the two mental states from whose encounter anxiety results. " I hope it will keep fine," we say ; " I am very anxious to play tennis this evening." But we also say : " My patient is not doing well ; I am very anxious about him." Even in such illustrations, however, both elements can be seen to be in the word though in each case one of them predominates.

Now anxiety is quite a common human experience, and can exist when the conflict between desire and fear is perfectly clear, conscious and obvious to all. It will persist so long as the individual, torn between desire and fear, has no outlet for energy in either direction and can only waste it in the production of anxiety symptoms. It will instantly vanish once an adequate degree of outlet is obtained ; that is to say, once he can whole-heartedly adopt some possible solution of the conflict as his goal, and put his energies into working towards it. It is quite immaterial whether the solution he adopts is a yielding to fear or to desire, so far as the cessation of anxiety is concerned. For that matter the conflict may depend on circumstances over which the individual has no control at all. A man who is waiting for the verdict of a jury which will determine whether he is to go into penal servitude or become a free man can hardly fail to be in a state of acute anxiety. The same is true of a man—or of some men—in the interval between proposing marriage and hearing the lady's answer. Once the jury have pronounced their verdict and the lady given her reply, their respective victims are freed from anxiety, whatever emotions may take its place.

Macbeth was in a pitiable state of anxiety before the murder of Duncan, and what his wife said about him was that he was letting " I dare not " wait upon " I would." But he ceased to be anxious the moment he reached a decision, and he said : " I am *settled*, and bend up each corporal agent to this terrible feat."

Now the " anxiety " of which constant mention is made in psychological medicine is something more than the anxiety we have just been discussing. It is morbid anxiety, or " Angst," and is the central symptom of all " anxiety states "—when that diagnostic label is correctly used. Morbid anxiety, nevertheless,

has precisely the same psychological origin as " normal " anxiety, though in the former case both the desire and the fear, or prohibition, are usually associated with powerful instinctive tendencies, the conflict is rarely or never consciously realised with any completeness, and many complicating factors are generally present.

We are not concerned with the theoretical or clinical study of anxiety states, but minor isolated—or apparently isolated—anxiety symptoms are so extremely common and are so constantly overlooked or misinterpreted that some further discussion of anxiety in general may be helpful.

It will be remembered that we cannot experience an emotional state for any length of time without linking it up with some object in our environment. The patient *must* find some object to which to attach his anxiety, and the familiar mechanisms of displacement of affect, rationalisation and projection all work overtime to help him.

It is important, therefore, to remember that the particular object or situation to which a patient attaches anxiety is rarely the " cause " of the anxiety, and still more rarely the only cause. It is the occasion and the opportunity—one of an infinite series—for something already in the patient to manifest and express itself.

A good-going anxiety neurotic—as well as many patients who are not so diagnosed—pours out his anxiety in some degree upon every circumstance and incident in daily life, though he naturally prefers a situation which would tend to rouse apprehension in a normal person on its own merits, so to speak.

To such a patient the mere sight of a policeman suggests thoughts of arrest and punishment ; all telegrams suggest possible bad news ; every stranger may be a thief and robber, and every summons to the chief's office may mean the sack. Strangely enough, when any situation does actually turn out unfavourably, the patient may tend to be better rather than worse. If the telegram contains not bad but good news, or if the visitor turns out to be not a burglar at all but a kind friend, the patient's anxiety—if it is anything approaching real morbid anxiety—is in no way relieved. Why should it be ? There will be plenty more telegrams and visitors to agonise over in due

course. But on the other hand, if the blow really does fall, the patient is in the happy position of being able to say "I told you so." Further, now that the worst has happened, he is for the moment released from his forebodings and very often may be temporarily stimulated into displaying the efficiency, the courage and sometimes even the heroism of despair.

How different is all this from the simple anxiety of a normal man, with all his psychological cards on the table, so to speak. In his case, the cause of the anxiety resides in the uncertainties of the situation, and once that uncertainty is resolved, no matter in which direction or by what agency, no further anxiety remains. If the worst happens, the ordinary man accepts the fact, does what he can about it, and tries to save something out of the wreck. If things turn out well, he thanks God and takes courage, experiencing a glorious sense of relief to which his neurotic brother is forever a stranger.

The student should constantly ask himself when listening to a patient's story whether or not the situation the patient describes justifies the degree of anxiety which he attaches to it. The fact that the patient's anxiety is obviously "genuine" is not really evidence either way, and to settle the point often calls for a good deal more patience and skill than the average student is in a position to devote to the attempt.

It is not really very difficult, however, to decide whether one is dealing with anxiety which is merely a natural reaction to a situation or with true morbid anxiety, if one is careful to look at the case and all its attendant circumstances as a whole, and remembers that morbid anxiety hardly ever appears as a bolt from the blue in a previously healthy person. The sufferers from morbid anxiety are the army of the psychologically half-hearted who have been letting "I dare not" wait upon "I would" for so long that this has become their habitual and almost automatic response to life.

It is not hard to see how this arose. The simplest and commonest and most harmful method of dealing with tendencies and activities which parents consider undesirable in a child is, of course, to make him afraid of them—or their consequences. This was the specialty in which Victorian parents are said to have excelled. Almost every natural childish activity had some mysterious, illogical and terrible punishment attached to

it, varying from solitary confinement on light diet for such misdemeanours as climbing trees or stealing apples, up to the wrath of God plus a beating from father for such capital offences as showing undue interest in one's sexual organs or those of others. No patient is likely to see life steadily and to see it whole, whose "shadowy recollections," far from being the fountain-light of all his day, are a remorselessly echoing "Thou shalt not," with its main variation, "Stop that, or father will be angry" or—in extreme cases—"Stop that, or God will be angry." Let his intellectual and physical development be what they may, the outlook of such a one on all his personal problems will be unbalanced and undeveloped.

But it is the bodily manifestations of anxiety which are of special importance to the student at this stage, because, as has been said, they are so commonly misinterpreted, especially when they appear more or less isolated and not as part of some fairly well recognised syndrome. These manifestations are indeed, to use Freud's word, protean. They include sweating, tremor, tachycardia, precordial pain, fainting, vasomotor disturbances, pruritus, vertigo, dyspnoea, asthma, dyspepsia, diarrhoea, polyuria, vomiting, dysmenorrhoea, neuralgia, and very many more.

Now a few of these symptoms, probably in very minor degree are, no doubt, within the personal experience of almost anyone who has gone up for a *viva voce* examination, sat in the pavilion as "next man in" on a sticky wicket, or waited "in trembling hope" for the lady who promised to meet him half an hour ago. Such situations are of common occurrence and have nothing really profound or unusual about them. The symptoms they provoke, however mild and transient, are often quite obvious and can be exceedingly unpleasant while they last. Surely, therefore, we should expect still more acute and obvious reactions to a situation which its victim feels to be a far more anxiety-producing ordeal than any of the above? Let us consider, for example, a first visit to an out-patient department by a worried housewife of indifferent education, accompanied, perhaps, by a crying child. She is not sustained by any interest in medicine and she is handicapped by sickness or pain as well as by misgivings about her own health or that of her child. Everything she sees and hears is utterly strange,

sinister and forbidding, and over the whole place broods the terror of the unknown. That is how she sees it, and it is not surprising that in spite of a reception as kindly as experienced and practical sympathy can make it, she exhibits a group of " anxiety-symptoms " in addition to those of which she " complains."

The general appearance and atmosphere of a hospital and its equipment are familiar in every detail to the student, who accepts them as a matter of course, and he sometimes forgets that they may be terrifying in the extreme to a patient. He should remember that many a student—he himself perhaps was one—has had to cut short his first visit to the operating theatre with more haste than dignity.

That the student will do everything in his power to put patients at their ease is not for a moment doubted, but he must constantly bear in mind that patients who are ill at ease will show it, not by telling him so, but by the production of a group of anxiety-symptoms which may lead him to place many an innocent stomach, heart or other unfortunate viscus under instant suspicion and urge that it be subjected to an exhaustive series of gruelling examinations and laboratory tests. If the patient should happen to be a true anxiety neurotic, with an additional group of symptoms quite unconnected with the immediate situation, the difficulty of recognising them for what they are will be by so much the greater.

But here, as in the case of " conversion-symptoms," the difficulty of differentiating between " functional " and " organic " is not nearly so great as most books and teachers seem to make it. The student cannot be expected to distinguish the two with ease until he has made a full clinical study of conversion hysteria and anxiety states. These are subjects with which this book does not deal. Enough, however, has been said in this and other chapters to help the student to come to intelligent and reasonably sound conclusions as between " functional " and " organic " in most cases. To ensure this two things in particular are necessary. One is a good sound knowledge of ordinary clinical methods. The other is the imagination—for want of a better word—which will enable him to put himself in the patient's place and view the situation from his angle.

Chapter 12

REHABILITATION

Rehabilitation is a word which is seldom absent for long from serious medical conversation nowadays, and I imagine that few of us have escaped attending conferences to discuss it or joining strong committees to organise it.

The dictionary says that it means : " The act of reinstating in a former rank or capacity ; restoration to former rights," but I think we shall have to go further than that if we are to reach a true understanding of it. It comes, as doubtless you know, from the French, and its literal meaning is " reclothing." The word " habit," in all its senses, comes from the same old French root. We talk of a riding-habit to this day, and to speak of someone being " habited " in this or that style of clothing is good Shakespearean English.

It is clear that whatever its original meaning may have been, the verb " to rehabilitate " does not now mean merely to get people new clothes, difficult enough though that feat is nowadays. The clothing is obviously not material clothing and, for that very reason, the derivation of the word and its use in this connection are profoundly significant. To take the word in its literal sense would be absurd and the fact that we use it at all shows that it can only mean something which we try to do for the patient closely analogous to the reclothing of his body.

Very well then, rehabilitation means metaphorical reclothing —and what does that mean ? To answer that question fully I suppose we should have to go back to study the philosophy of clothes as expounded in that wonderful but now neglected classic, *Sartor Resartus*—the tailor rehabilitated. I think, however, that we can investigate the matter sufficiently for our purpose rather more briefly than Carlyle did.

Clothing can be regarded as a form of display, a protection, a form of concealment, a concession to decency, a convention, and in many more ways, but it is not unfair or inaccurate to say that essentially our clothing is simply our adjustment and

adaptation to external conditions and to the demands of the society in which we live.

In extremes of heat and cold for example, most men and some women care less about the style and fashion of their clothes than about their suitability to the temperature and climate. Again, nothing destroys more quickly and certainly that sense of harmonious contact with one's fellows on which true happiness so largely depends, than appearing among them inadequately or unsuitably dressed for any particular occasion.

We may say then that rehabilitation—metaphorical re-clothing— means the helping of an individual to readapt himself to circumstances and society, and we are repeatedly told that it is simply the medical aspect of the whole great process of national reconstruction.

Reconstruction : that is the thing on which the real experts, the big men, are engaged. But all must take their share in the task, and while everything, including our own profession, is being reconstructed, we can employ ourselves usefully and helpfully in rehabilitating patients. That is the doctor's job.

There is certainly a vast field for our activities. There are ex-service men and women to be rehabilitated after injury and disease, and there are exhausted and war-shocked civilians to be rehabilitated, and there are evacuated children and diabetics, and orthopaedic cases, and the problems of tuberculosis and venereal disease to be tackled. And that leads on to questions of housing and sanitation and hygiene and the whole enormous subject of public health, and that is certainly a large and vitally important part of reconstruction which goes far beyond individual cases and calls for medical planners of first-rate ability and vision and organising power to co-operate with the political and social and educational and economic architects of the brave new world. Yes, but let us go just a little slower. The great majority of us have to earn our living by attending to our patients in the routine of the day's work. There is Mrs. Black with a malignant breast, and Mr. White with osteo-arthritis, and Mrs. Smith who wishes she were pregnant and isn't, and Sarah Brown who wishes she weren't pregnant and is, and old man Jones whose bowels move about once a fortnight, and the child with chorea, and that nice boy

with broncho-pneumonia, and, of course, Willie Green who got off fire-watching because somebody said he had an anxiety neurosis. And many more. And we don't have much time or opportunity to get beyond all that and do our share of " medical planning."

I shall have something to say shortly about medical planning and " reconstruction " in general, but first I should like to remind you of the relation of the apparent trivialities I have just mentioned to the more spectacular activities of the planners. For whom are the plans being made ? Who is to benefit from the public health measures ? Who is to inhabit the reconstructed world ? Your patients and mine, and the patients of our colleagues, and the whole mass of individuals whom we tend to refer to airily as " the community " and whom we group into a few arbitrary subdivisions which we call " classes " or " sections " or " types."

Surely a doctor should not require to be reminded of the futility—the impossibility—of mass treatment of any community without regard to the individuals of which that community is composed. Who knows so well as he the amazing variety of constitutions and temperaments and reactions and illnesses and outlooks and needs to be found in a single street—for that matter, in a single family ? Is there any doctor who would not agree that the success of his work in general can only spring from, and be judged by, the success of his approach to and his dealings with each individual patient ? This seems such an elementary and self-evident proposition that it is surprising how we tend to ignore the equally obvious truth that follows immediately from it, namely, that national rehabilitation must be preceded by individual rehabilitation and can only come about by means of it. All history and every day's experience prove over and over again that any advance or reform or scheme for the benefit of any human community which becomes so concerned with general principles that it ignores individual personalities, is built upon sand and can only end in futility if not in disaster.

I think we are all in danger of forgetting this, perhaps because it can't be denied that one extracts a certain satisfaction from joining a committee or addressing a meeting or writing a letter to the Editor, which is absent from attending to a

patient with chronic bronchitis. And this is right enough. Where there is no vision the people perish. Enormous problems are before us, and it is our right and our duty to form and express our own views and to help in planning according to our opportunities and abilities. But don't let that blind us to the truth that to get anything really done, we must in the long run fall back on nature's old-fashioned, slow, but terribly certain, one-by-one method, of working from within outwards. No rule or principle or way of life imposed on a community from without, and applied by rule of thumb, as it were, has any real chance of being accepted and absorbed, of exerting any lasting influence or of yielding any permanent result. The fact that such an attempt, on an enormous scale, is the very thing we fought against, should help us to remember that truth. It applies in every department of life, and particularly to public health and rehabilitation measures. Guidance and instruction and arrangements and facilities are of course very necessary, but the actual motive power must come from the individuals of the community concerned, and work from within outwards, and that is why I took care to say a few minutes ago that rehabilitation is the helping of an *individual* to adapt himself to circumstance and society. The thing is really ludicrous in its simplicity, if we would only face it. Our individual patients—fussy or placid, cowardly or brave, acute or chronic, ignorant or wise, trustful or doubting, curable or hopeless—are the stuff of which the rehabilitated community will consist. We don't know how fully we can rehabilitate any of them. We don't know what proportion of them we can rehabilitate at all.

We must all have been struck by the strange silence upon parallel questions in public discussions and pronouncements on, for example, social reform. I have yet to hear from a platform or read in a newspaper what is to happen to a " worker " who does not want to work, to a youth who idles away his equality of opportunity, to a man who prefers dishonesty and extravagance to rectitude and thrift. And yet I fancy that a few such people will make their appearance from time to time. We need not discuss why we never hear about them, but we can try to avoid self-deception in the medical sphere and to face the facts in all our planning.

Let us face once and for all the fact that if there is going to be

any national rehabilitation at all its mainspring will not be the efforts of the planners, plan they never so wisely, but will be, and must be, and can only be, the activities of the men and women who have themselves been rehabilitated one by one. How could it possibly be otherwise? A cathedral in every village would not abolish irreligion, nor would a public library in every street produce a nation of scholars. Membership of the House of Commons does not make a statesman, nor is the possession of a modern operating theatre any guarantee of a successful operation. Have we any reason whatever to believe that hospitals, or garden cities, or model villages, or ideal homes, or labour-saving devices, or modern sanitation, or welfare councils, or pre-natal clinics, or isolation blocks, or tuberculosis sanatoria, or epileptic colonies, or notification of disease, or public health measures of any description, including the most completely organised medical "service," are able to make anybody follow the simplest and most elementary rules of personal health and hygiene, unless he wants to? All history, experience and common sense unite in telling us that we have not. Where is the machinery that can compel cleanliness, temperance, adequate hours of sleep and fresh air, suitable recreation, faithful carrying out of treatment, selection of proper diet, prompt recourse to medical help, acceptance of medical advice, and above all, that courage, optimism and "will to live," which, as we all know so well, are often nine-tenths of the battle? The machinery exists, but you will not find a trace of it in any scheme of medical planning no matter how far-reaching or enlightened. You will find it only in the minds and hearts of the individuals concerned, and I will add the rather sobering reflection that even there you will find just as much of it as you are able to appreciate and understand, no more and no less. Sometimes, though rarely, you will find it working to the limit of its capacity; more often it is merely "ticking over," in need of some degree of adjustment or repair, and waiting, not for some plan, or regulation, or rule, but for some *person* to activate and energise it and restore its power to influence with beneficent and compelling force, first, the health and happiness of the individual himself and then, through him, the collective health and happiness of the society in, by, and for which he exists.

To avoid any possibility of misunderstanding let me repeat yet again what I have already tried to stress. Enlightened medical planning and modern public health measures, and the various remedial agencies I have enumerated, and many more, are all necessary and right and deserving of the highest praise. But unless they go hand in hand with the equally essential—I am tempted to say the more essential—process of dealing with individuals and enlisting their co-operation and help, they will, of themselves, be little or nothing worth, because they will mistake the shadow for the substance and concentrate on the frame to the neglect of the picture.

If it is not labouring the obvious, I invite you to consider the disappointing and incomplete results achieved in, for example, such spheres as venereal disease, child guidance, and so-called mental hygiene, to name but three, where what I may call the public or communal approach (excellent as far as it goes) has outstripped and over-shadowed the personal and private one.

Who, then, is to deal with the individuals who don't want to be well and who won't go marching towards a medical millennium like an army of well-ordered puppets? The doctor, of course, and nobody else. We and we alone can get so much as a hearing from a man who is exercising his inalienable right to neglect his health, to refuse treatment, to ignore advice, to drink himself to death, to live in squalor, to break his wife's heart, or to ruin the nervous systems of his children. If that is anything like true, and most of us know that it is, then it would appear that the individual doctor's share in the great work of rehabilitation, far from being of minor importance, is one of unique significance and value.

Now let us look into his task a little more closely. It would seem, from all we hear about it, that rehabilitation is a big job in which all the branches of medicine and surgery are interesting themselves. Rehabilitation centres are springing up for most of these branches, with the appropriate specialist or team of specialists in charge, and that they do excellent work is not questioned. I had occasion to look into this matter with some care several months ago when I was invited to give a few lectures on "The Psychological Aspect of Rehabilitation" to students of massage, medical gymnastics, electrical treatments and all the varied procedures which are nowadays grouped

under the extremely interesting and suggestive title of " physical medicine." Before I had got far in preparing the lectures I realised that it is stupid to talk about the psychological aspect of rehabilitation. If the word is properly used there isn't any other aspect, and the whole thing is applied psychology from first to last.

It is astonishing that this obvious truth has become so overlaid by confused thinking and conventional talk. It is illustrated in every single branch of medicine and surgery and, strangely enough, most readily and vividly in orthopaedic surgery and physical medicine. I need hardly point out that merely supplying a man with, say, an artificial limb is not rehabilitation, any more than supplying him with a new collar-stud. Rehabilitation does not even begin until after you have trained and educated him in its use. After that preliminary process, which itself is largely psychological, is over, you can begin true rehabilitation—the helping of the man to adjust his activities and ideas and outlook to the new conditions. And if that is not psychological medicine, nothing is. The extent to which he will need such help will of course depend entirely on the stability and adaptability of his own psychological outlook, just as the time and trouble it cost him to get accustomed to the use of the limb at all depended largely on the very same thing.

To take an even simpler everyday instance, have we not all known some people whose dentures never caused them a moment's discomfort from the day they were first fitted, and others who have complained bitterly and unceasingly of theirs till the day of their death ? What do you think is the essential cause of the difference ?

The time it takes to restore full functional activity to wasted muscles and stiff joints by means of massage, passive movement and so on varies enormously with different patients whose disabilities seem identical, and we all know very well that one masseur may get a wonderful result with a patient after another of equal skill has completely failed. Functional symptoms are notoriously prone to attach themselves to joint or muscle injuries, and cluster round them, as it were, obscuring the whole situation and delaying recovery, sometimes indefinitely. Such patients have a perverse way of actually refusing to believe the surgeon when he tells them that there is " nothing wrong with

them now,"—a fact which somehow seems to incline him to hand over the problem of their rehabilitation to somebody else. The extraordinary variations in response to treatment shown by "compensation" cases form too familiar and obvious an illustration to call for comment. Physical medicine is literally crammed with psychology, and the re-education which is such a large part of it is psychology and nothing else. The vast specialty which began by modifying the lay-out of work-rooms, changing the position of benches, varying the height of chairs and so on, frankly called itself Industrial Psychology from the start, and its subsequent development has very fully justified the title.

All this, of course, and much more is true of convalescence, of which we hear so much nowadays. I don't think anyone would seriously dispute that nine-tenths of the value of any convalescent establishment lies in its "atmosphere," but it is worth while to refer to the organised occupation which is very rightly being made such a prominent feature of all convalescence.

Occupation therapy has been hailed with such naïve enthusiasm by many of the public as something entirely new, that I suppose there may also be some who think that it is a form of physical treatment. I hardly think it worth while to argue the point, nor do I imagine that any of you will need much convincing that it is, in fact, one of the most effective of all forms of *psychological* treatment. I may point out, however, the amusing fact that this form of treatment was taken wholesale from those abodes of darkness and ignorance, the mental hospitals, where occupation therapy, the learning of trades, handiwork of every description, organised games and gymnastics, community singing and all the rest of it, have been going quietly along for many years. As to the novelty of these methods of ministering to minds diseased, I can but say that I possess an old Annual Report which shows that in at least one lunatic asylum, as they called it then, they were going strong in the year 1875.

Have you ever tried to rehabilitate a patient who had lost his eyesight by accident or enemy action? If so, I am sure that you did not find your knowledge of ophthalmology to be of any help to you—or to him. The "psychological factor"

as they call it, in tubercular patients, is universally admitted, and it is hard to see why such a factor should be denied to patients who are asthmatic, or crippled, or bronchitic, or deaf, or anaemic, or dying of inoperable carcinoma, or even suffering from nothing worse than avitaminosis. Of course their troubles may be merely matters of outside circumstance with which scientific medicine has no real concern : trifles like having had their home blitzed, or their son killed in action, or their daughter seduced, or perhaps just feeling utterly fatigued and "fed up with the whole show," or nursing some grievance which is a very petty one and ill-founded anyhow, but which they feel bitterly. I shan't add to the list, but simply ask if you think that such things might perhaps have a psychological effect on a patient, and whether you think they must be dealt with or ignored in any attempt to rehabilitate him. The answer is, I think, pretty obvious, and it raises in its turn the further question of who is to do this great psychological work which is the essence of medical rehabilitation and which only begins when the specialists in surgery, or orthopaedics, or dietetics, or opthalmology or whatever it may be, have made their admittedly invaluable contribution and gone on to the next patient. It might be thought that if what I have said is anything like true, the real work of rehabilitation must be carried out by the specialist in psychological medicine, but this is not so. It is not a task for the trained psychiatrist, nor yet for the skilled psychotherapist, and still less does the problem come into the domain of that hybrid specialty which carries on its activities under the title of "neuro-psychiatry."

Remember what we are trying to do : to help individuals—just ordinary everyday individuals—to adapt themselves to life. It may well be that in their earlier stages many of these patients needed a psychiatrist rather than any other specialist, and it is true that the psychotherapist has a better chance than any other specialist of seeing a case through to the happy ending. But when he does so, as he occasionally does, it is not only because he is a psychotherapist, and even if there were enough of him to go round, which there are not, he would not necessarily be the man for the job.

No, if the job is to be done at all, there is but one man for it—the general practitioner. I think most of us have known that

all the time. It would be needless and embarrassing to enlarge just now upon the relation of practitioner to patient. Both parties understand it, and that is good enough. It is very true that at times we have hard things to say to each other about our patients, and very much harder ones about their relatives and, on the other hand, I don't suppose that all our patients really prize us at quite our full worth—but that is all in the day's work. It doesn't alter the fact that patients will take their doctor into their confidence and into their lives so much sooner than anyone else, that five times out of six it is a case of the doctor first and the rest nowhere. They will accept our explanations and opinions with a wonderful and pathetic confidence, they will do as they are advised, more often than not, with a splendid loyalty, and they will quietly accept from us warnings and reproofs and good old-fashioned scoldings which they would tolerate from nobody else on earth. If the doctor wants to, he can make almost what he will of this unique relationship, the right use of which is the royal road—the only road—to true rehabilitation. He, and only he, can ascertain at first hand the patient's own view of his illness, he alone can first and best discover where the psychological shoe is pinching, and relate the patient's need for rehabilitation to his attitude towards life as a whole. Doubtless a knowledge of medical psychology will help him in this task and make him the right sort of doctor, but a knowledge of human nature will at least keep him from transgressing psychology's principles and will show that he is the right sort of *man*. And in this matter of human contacts, that is what really counts.

There are frail and sickly patients to be revitalised, there are stubborn and perverse ones to be made co-operative, lazy ones to be made active, sulky ones to be made friendly, disgruntled ones to be made cheerful, humbugs to be made sincere, cowards to be made brave, weaklings to be made strong. That is rehabilitation indeed, and if the personal efforts of a patient's own doctor fail to achieve it, then I know of nothing else on earth that has much chance of succeeding.

The heart of the whole matter—the very essence of it—lies in this personal relation of doctor to patient. It always has done so, and it always will do so. Though we are right to guard it jealously as our unique privilege and trust, we need not fear

for it, nor be too vocal in its defence. It will endure so long as we remain worthy of it, because it is founded deep in human nature and no scheme or report or committee shall ever prevail against it.

I said at the beginning that planners and reconstructionists are most necessary, and naturally they must have their machinery of councils and conferences and committees. Of course there are committees and committees, and it is not for me to say whether any still exist where, as Tennyson put it :

> " . . . . . blind and naked ignorance
> Delivers brawling judgments unashamed
> On all things, all day long."

I hope not. I only know that the best work of the ideal committee is bound to be incomplete in any matter where individual conduct and reaction and personality are involved ; and rehabilitation is pre-eminently such a matter. I know, too, that in the joy—for it can and should be a joy—of planning on a great scale, applying logical principles and mass statistics with wisdom and vision and skill, it is terribly easy to forget that one is dealing with human material. The individual personal factor will invariably elude and often stultify such planning, because it can never be confined within the boundaries of a formula or shown upon a blue-print.

I have often thought it strange that so many of our very practical race should have become literally hypnotised by some of the most mystical verses in our language. We are surrounded by immense numbers of people who never tire of informing us in vociferous chaunt that they will not cease from mental fight nor shall their swords sleep in their hands till they have built Jerusalem in England's green and pleasant land.

No doubt " mental fight," is an elastic term, and there may be those who think it covers and justifies such things as, for example, some of the questions and debates in Parliament, the bickerings of local authorities, the wranglings of rival philanthropic agencies, the bitterness of newspaper politicians, the clamour of mass-meeting orators and even the differences that arise among members of strong committees. I can hardly believe, however, that this is precisely the kind of mental fight which the poet had in mind.

I wonder how many of our choral Jerusalem-builders are aware that there were once people who actually and literally did build Jerusalem, or at least rebuilt its walls, in its own land? We possess an admirably clear and interesting report of this piece of reconstruction, written by no less a person than the Clerk of Works, and I wish it were possible to make every reconstructionist, whether chorister or committee member, learn it by heart. It opens with a realistic and, indeed, pessimistic summary of the situation :—" The strength of the bearers of burdens is decayed and there is much rubbish, so that we are not able to build the wall." There is much rubbish. How right he was—and is.

It seems that then, as now, the sub-committee menace was rampant, and this is how it was dealt with. " They sent unto me, saying, Come, let us meet together in some one of the villages. And I sent messengers unto them, saying, I am doing a great work so that I cannot come down. Why should the work cease whilst I leave it and come down to you? Yea, they sent unto me four times after this sort and I answered them in the same manner." Fancy refusing four invitations to join a Committee!

Finally, triumphant success and the reason of it are reported in the simple words :—" So we built the wall, for the people had a mind to work."

That surely is the conclusion of the whole matter. We are are all trying to take a share in the work, and the one thing that matters is that our contributions shall not follow the easy road which avoids essentials and ends in elaborate futilities, but shall take the way of personal effort to make our patients—the people who need us and who trust us—fitter in body and mind to adapt themselves to new conditions and play their parts in the better days to come.

That is the essential thing for us as doctors, and if we have it as our aim it matters not how amateurish and ineffective we may sometimes feel our best efforts to be. By all means let us go further and help in organising and planning the building of the wall if we can, but remember that even the strongest walls have limited functions and that all our planning is but a frame for the picture we are trying to draw.

It was the famous Wise Men of Gotham who were so charmed

with the melodious notes of a cuckoo which had perched on the local tree that they held a committee meeting to consider plans for retaining the bird in the village. They decided to build a wall round the tree for this purpose. It was a very good wall indeed and there was genuine surprise and much disappointment that it failed to imprison the bird.

There was once a small girl who, busy with paper and pencil, announced to a startled nursery that she was drawing a picture of God. Her mother, rather taken aback, pointed out that nobody had ever seen God and nobody knew what God was like. " No," replied the child, " but they will—when I've finished my picture."

Chapter 13

DOCTOR AND LAWYER

Later on in your course of studies you will read, or be advised to read, various excellent text-books on forensic medicine which contain full information as to your medico-legal duties and responsibilities. By careful study of these volumes and timely reference to them when need arises you will doubtless succeed in performing any medico-legal duties that may come your way adequately enough, and in avoiding any serious collision with the law or its officers. It is certain, however, that even mastery of the collective wisdom of all these books would be no guarantee against your cutting a very poor figure in a witness box.

It has always seemed to me that the text-books—no doubt remembering that "de minimis non curat lex"—do not concern themselves with the practical, human and, so to speak, unofficial aspects of the relationship between doctor and lawyer. As with so many other apparently elementary matters the junior student's teachers ignore them, the senior student's teachers assume that he knows all about them, and the graduate has to learn them, if at all, by painful and embarrassing experience.

This chapter deals solely with a few of these practical points, and does so in a very informal fashion. It contains nothing that will help you to pass an examination, and nothing that will relieve you from the necessity of learning the technicalities of forensic medicine as well and as thoroughly as you know how. On the other hand it contains material which you will not be able to look up in a reference book when required and which may help you some day to ease a difficult situation or avoid a humiliating one. If you read it at an early stage in your career you are more likely now than later to forgive it for not being scientific and for descending unashamedly to the level of "hints and tips," and "do's and don'ts," or very near it. Also, it fits appropriately enough into this book because the points it raises are simply matters of that elementary applied

psychology which is indistinguishable from common sense. I hope that some of them may remain in your memories and come to your assistance in the future, perhaps on some day of wrath when your tongue cleaves to the roof of your mouth and you feel incapable of writing your own name. Such things do happen, especially in witness boxes.

The first person we must talk about is the solicitor. Apart from formal or routine matters such as statutory certificates of various kinds, returns, notifications and so forth, which need not concern us just now, every contact you make with legal matters is, or should be, through somebody's solicitor. You should never undertake any responsibilities or perform any services other than medical ones on behalf of a patient without first offering to communicate with his solicitor, and, very often, insisting upon it. It is astonishing how easy it is to neglect this safe and simple rule. In a well-meant effort to help, one witnesses some legal document, reports to some firm of employers or takes sides in some family dispute without reference to the patient's solicitor, and the mischief is done. Even if they cause no irreparable harm such proceedings rouse a solicitor to a high degree of perfectly righteous anger, and will not be forgiven you by him.

You must remember that the solicitor-client relation is quite justifiably regarded by most people as more personal, important and confidential than the doctor-patient one, if only for the reason that it holds both in health and sickness, throughout life and after death as well ! It is also worth noting that a doctor can be compelled by law in certain circumstances to disclose facts concerning his patient, whereas a solicitor cannot be so compelled with regard to his client. Solicitors very properly value their professional status highly, guard it jealously and are apt to be just as touchy about it on occasion as doctors are about theirs. You will be wise, therefore, to treat them with all due courtesy, and to apply Bacon's admirably shrewd advice with regard to colleagues : " Respect them, and rather call them when they look not for it than exclude them when they have reason to look to be called."

When writing or talking to them about Mr. X, don't fail to refer to him at least once and preferably oftener as " your client," no matter whether Mr. X is a stranger to you or has

been one of your " regulars " for years. This small courtesy indicates that you understand your position in the matter and have no intention of going beyond it. As a result you will find your opinions listened to with an attention and indeed a deference which may surprise you. Once you have made it clear that you are limiting yourself strictly to the purely medical questions in the case, you should accept all the responsibilities which they involve without hesitation and discharge them without fear. You will almost invariably receive invaluable encouragement, support and co-operation once you have shown that you have no intention of going beyond your medical duties on the one hand, or shirking them on the other.

Never be afraid of saying that you don't know, or that you were wrong. A solicitor knows better than anyone else that nobody is omniscient or infallible. He makes his living very largely out of that fact. Tell him fully all the opinions you are prepared to give, or the actions you are willing to take in your report or evidence or whatever it may be, and you will rarely, if ever, be pressed to go beyond them. You can, however, and indeed you should, ascertain from him the exact points he wishes you to bring out, or line of action he wishes you to adopt. If you cannot act as he wishes tell him so and explain as clearly as you can the medical objections to the course he proposes. You will very often be unable to go as far as he would like. This is natural enough if you remember that he is concerned with his client's interests from a legal standpoint and with nothing else. Your medical conscience is not his responsibility. He is none the less a professional man like yourself, and if any reputable solicitor comes to the conclusion that your professional conscience is an elastic one, he is extremely unlikely to have anything more to do with you.

When the possibility of having to give evidence in court is concerned, there is a very important point which must never be forgotten, namely, that you are liable to be cross-examined. This is a very different matter from arguing in favour of your views before a medical society. It is a matter of answering a multitude of questions (most of which will seem utterly irrelevant and bewildering to you) put by a layman whose one object is to discredit your evidence if he can or, failing that, to water

it down and minimise its effect by every means in his power. You should therefore discuss with the solicitor any weak medical points in what you propose to say. You can easily discover these by imagining how you yourself would attack your evidence if it were given by another medical man, and you were on the opposite side. You must also ask him what points in it are likely to be attacked from the legal side. Nothing is more helpful and instructive than considering these two quite different groups of vulnerable points, and time taken in forearming yourself against cross-examination in this way is well spent indeed.

This brings us to the question of medical evidence in general. It should first be made clear that you may be called to give evidence as a witness to fact, or as an expert witness. Without going into needless details and technicalities, the chief differences between the two can be summarised clearly enough. In the first case you are called to testify to something you have done or said or written about a patient, you can be compelled to attend and often you have no say in the matter of your fee. In the second you are called as a specialist or expert in some branch of medicine to state your findings and give your opinions on matters which are incapable of direct legal proof, and with which you may have had no concern until you were called in by one side or the other. You are under no obligation to enter the case and if you do your fee is a matter of private agreement.

Unfortunately this distinction is not as clear in practice as it may seem, because the legal idea of what is " fact " differs very greatly from the medical one. The very simplest medical principles and axioms and aphorisms which we regard as fundamental are the happy hunting-ground of the lawyer who challenges them gleefully when it suits him, secure in the knowledge that they are incapable of proof in the legal sense and that most of them have been contradicted at one time or another in some medical writing or by some exceptional case. " If T. A. Edison could get along nicely with only three hours' sleep each night, why can't Mr. John Smith ? " " In this book Dr. A. B. says he treated five hundred patients by depriving them of food altogether for three weeks, and that at the end of that time they were all much lighter in weight and pocket, and

infinitely healthier in body and mind. Do you wish to contradict this eminent physician by saying that insufficient food can possibly . . . . . etc. etc. ? " This kind of thing can be very maddening until one becomes used to it, and I have left a court more than once feeling that nothing could really be proved except things that weren't worth proving.

When called as a witness to fact, your safest and wisest course is to confine yourself to fact as far as you possibly can and refuse to be drawn into any general statements or anything beyond the most direct and simple inferences from your own observations. To any attempts so to " draw " you, you will do well to reply " I do not know. I am not an expert. I think so-and-so in this case, but on the general question I am not in a position to speak with authority." It is much better to say this yourself than to have it said to you, as it certainly will be if you give the slightest opening for it.

Never hesitate to agree cordially with suggestions that your experience is limited, that you have sometimes made mistakes in the past, that doctors have been known to disagree, and so on. If you can summon a cheerful smile while dealing with these well-worn pleasantries, so much the better. On the other hand, deny with equal cheerfulness, but firmly and explicitly, any suggestions that in the particular matter in question you have forgotten, or have made a mistake, or are not quite sure. There is no need to become righteously indignant about it. You can look on this part of the proceedings as a game, the object of which is to make you lose your temper. If you keep it, you win.

In cases of any importance you will be examined and cross-examined by a barrister.

The relation of solicitor to barrister is in some respects analogous to that between practitioner and consultant, though of course this analogy cannot be pushed too far. It is the duty of the solicitor to prepare a case that is going into court as fully as he can for the barrister whom he has asked to conduct it. Once the case comes into court the barrister is the only person whom the judge can " hear " with regard to it, whereas everything outside the court is done by or through the solicitor. What follows relates more to expert witnesses than to witnesses of fact and to big cases rather than petty ones, but much of it

is applicable to medical evidence in general whatever the particular circumstances.

It is obviously a great advantage to have a talk beforehand with the man who is going to examine you in court, particularly if the case is a difficult one and you are likely to be asked for opinions as well as facts. It is thus an excellent practice to ask for a consultation (lawyers call it a conference) with the barrister before the case comes on. This must only be done through the solicitor. It is a definite breach of legal etiquette (which is in many respects more elaborate and rigid than medical etiquette) to approach a barrister directly, and if you do he will probably tell you very courteously that he is unable to " hear " you. You should therefore say to the solicitor that you think a conference with counsel would be a very helpful thing, if he thinks proper. As a rule he will be only too pleased to arrange it and he will of course be present himself, as otherwise counsel would unfortunately suffer from the technical deafness to which I have already alluded.

It should be emphasised here that it is never a mistake to be punctilious over these little matters of procedure and etiquette, and it is always a mistake, and usually a grave one, to stand on one's dignity, to be " difficult " about times of appointments, to bewail the time lost in attending court or to grudge any time or pains spent in informing yourself thoroughly of every detail of the case and getting its general " atmosphere." At the end of a conference at which an additional report from a medical witness was required counsel asked him to post it to him direct as it was a matter of great urgency. The doctor took the trouble to telephone to the solicitor at his own house that evening to obtain his permission to do this and, by this possibly needless piece of formality, made lasting friends with the firm of solicitors who refer to him constantly as a man who knows how to behave in legal matters !

At such a conference you will find that counsel is naturally very much in the chair, and you will have the opportunity of studying the legal outlook on the case at close quarters. This, as well as the subsequent court proceedings, can be one of the most fascinatingly interesting things imaginable, and it is a matter for regret that so many medical men detest medico-legal work and avoid it whenever possible.

Counsel, who will have your routine report before him, will tell you the line he proposes to take but, contrary to popular belief, neither he nor anybody else will make the slightest attempt to push you farther than you want to go. He will give you valuable information as to the kind of cross-examination you may expect and he will reassure you if necessary by telling you that a medical witness who knows his work and realises his function has nothing to fear in cross-examination.

The business of counsel is not directly to find out truth. It is to establish as many facts as possible which are in favour of the case he is presenting, to interpret all the circumstances as favourably as he can, and to make as little as possible of facts or suggestions which would tell against the point of view he is supporting. His own personal opinions on the rights and wrongs of the case do not come into the matter at all and it is a gross breach of legal custom and etiquette for him to give any expression to them.

The judge, as you know, directs the jury on how the law of the country applies to the particular case, and he leaves to them the decision as to which of two or more disputed versions is fact. This decision is reached upon evidence alone, and the rules governing the giving of evidence and all matters connected therewith form a highly complicated legal specialty. You must be prepared, therefore, not to be allowed to give your evidence in the manner you may think best, and you must also be prepared to find what may seem to you to be unimportant side issues treated at great length. We need not pursue this further beyond saying that it is opposing counsel's right and duty to pick any holes he can in your evidence and to convey to the jury the impression that it is not really as well founded as you would have them believe. If you assist him in this invidious task by vacillation and hesitancy, or even more by being pompous, verbose, dogmatic or irritable, so much the better for his case.

The function of an expert witness is to assist the court by giving expert opinion on matters of which the jury have no experience and on which they cannot be expected to judge. It is most important, therefore, that the medical witness should be as restrained and impartial as is humanly possible, and especially that his manner to cross-examining counsel should be

as pleasant and as courteous as it is to his examiner-in-chief. One should aim at betraying no personal feeling in the case, and indeed no special concern as to its outcome. You are there to assist the court and you must accept the fact that its way of getting at truth is not the same as yours for the excellent reason that the problem before it is not, as you are often tempted to think, a medical one, but a legal one. Many things hinder this ideal attitude, the chief one of course being that in the present state of the law you are approached by one side or other, and it is inevitable that you should therefore tend to have a certain interest in its success. This difficulty is very much more acute in civil than in criminal cases. In the latter we rarely or never have the sorry spectacle of teams of specialists on opposite sides. It is usually for the medical man a question of whether the accused was or was not criminally responsible, and although that question has its own peculiar difficulties to which I shall allude shortly, the prosecution (that is, the Crown) is never vindictive and, as a rule, relies on its prison medical officers alone for medical evidence. A civil case is a very different matter inasmuch as there is nothing to prevent either side calling as many specialists as they are able to pay. Further, there is no question of crime involved and there is usually a good deal to be said on both sides from a medical point of view, so that we have the unedifying sight of distinguished medical specialists appearing to contradict each other utterly, with a regrettable lowering of the dignity and prestige of our profession as a result. What makes the matter much worse is that if the medical witnesses were discussing the case at the bedside or at a meeting of a medical society there is little doubt that they would reach a ninety-nine per cent agreement about it in a very short time. One cannot do very much to alter this state of things, but attention to one or two practical points may help you in such painful situations and sometimes even enable you to avoid them altogether.

Never agree to give evidence in any case until you have studied all the relevant papers with which the solicitors can provide you. During such study you will no doubt find some medical points on which your opinions would help the side that has approached you, but I would very strongly advise you to put these aside before coming to a final decision, and consider

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the case as a whole. If it does not commend itself to you (in a way which is impossible to describe but is very real when experienced) as a case which you can take up whole-heartedly you should have nothing to do with it. No fee and no kudos can be sufficient to compensate you for the unpleasantness and difficulty which inevitably result from any attempt to give evidence in a case in which, from the medical side, you do not whole-heartedly believe. You need never hesitate to inform the solicitor that after considering the papers he has submitted, you are sorry that you are unable to give evidence which would assist his client's case. If, in such circumstances, you are later approached by the other side you are, of course, debarred from accepting their invitation to give evidence by a universal professional tradition which, as far as I know, is never broken.

The foregoing applies principally to civil cases and especially to cases where the question of medically examining a patient does not arise, for example, " will cases," regarding which I am increasingly inclined to summarise my advice in the words " Leave them alone." The medical man who gives " expert " evidence concerning someone whom he has never seen and will never see, is usually—not quite invariably—looking for trouble and is more than likely to find it. Of course, evidence about a deceased patient whom he saw and attended when in life is an entirely different matter.

When your expert medical evidence is sought as to the bodily or mental state of some person who is living and available for examination, you will, of course, rarely " turn down " the case without examining the person as well as studying the papers. The usual procedure is to inform the solicitor that you will study the case, examine his client, and send him a report stating your opinions on the questions he raises and outlining the evidence you are prepared to give. This commits you to nothing further, and you should regard it as a separate transaction in itself and charge a suitable professional fee. If, in due course, the solicitor tells you that counsel thinks you should be called, you then agree to prepare your evidence (which may very probably involve seeing the client again and attending a conference with counsel), and to attend at court to give it. So many things affect the amount of the fee you should charge for

this that no advice on the point is possible except that you will often do well, if you are uncertain, to discuss it frankly with the solicitor or with some experienced medical colleague. There are two other points, however, on which very definite advice can be given. The first is that the fee should be for preparing evidence, etc., and for *attendance at court.* Cases have a way of getting themselves settled or postponed, or counsel may decide at the last moment that your evidence is not required. It is well, therefore, to make quite certain beforehand that you will be properly recompensed for your attendance at court even if you do not give evidence. The second is that you should make it plain that your fee is payable at the conclusion of the case. A fee that has been agreed by a reputable firm of solicitors is undoubtedly as " safe " as if it were in your pocket, but the law's delays are proverbial, and there is no earthly reason why the expert witness should wait for his fee till endless formalities with which he has nothing to do have been completed.

The ideal at which to aim in the witness box is entire naturalness, ease and directness of manner, and the more desperately you are striving to recall eleventh-hour pieces of advice, the less likely are you to attain this. It is well therefore to have made long beforehand various small points of conduct into something as near to conditioned reflexes as possible.

The first of these is audibility. All human beings tend to become irritated when they cannot hear clearly what is said in their presence, and judges are outstandingly, and even notoriously, human in this respect. Assume—as the judge will, should the point arise—that it is your articulation which is at fault and, without shouting, speak as clearly and distinctly as you possibly can. Almost all counsel, by the way, seem to be gifted with preternaturally acute hearing, doubtless acquired by years of struggle to disentangle the murmurings of nervous witnesses from the constant swinging of glass doors, comings and goings of small legal fry, whispers of court officials, *sotto voce* arguments at the solicitors' table, and confused noises without, all of which combine to form a background closely resembling pandemonium until one has accustomed oneself to it—for which purpose a few preliminary visits to a court as an onlooker are strongly recommended.

Sometimes by a regrettable accident counsel's acute hearing

fails him, and when he repeats your reply to a question you may find that he has got a few words wrong. You must correct him at once, repeat once more what you did say, and express regret for having dropped your voice and/or having failed to make yourself quite clear. He will thank you very cordially, express his regret for the error, and proceed as before.

As a rule it is desirable and necessary to speak very slowly. Even if there is an official shorthand writer the judge takes notes of his own, and each judge is a law unto himself as regards the amount he writes and the speed at which he writes it. You will be fortunate if you escape at least one injunction to speak more slowly (or, rarely, more quickly) but if you keep a wary eye on the judge it is not usually difficult to adjust your *tempo* to his satisfaction. Counsel are very helpful as a rule in this matter, seeming to know in almost uncanny fashion when it is permissible for you to go full steam ahead, so to speak, and when you must essay that most difficult task of an expert witness, the exposition of a technical point in a minimum of words at dictation speed.

Every word you say must be carefully considered. The importance the law attaches to the actual words spoken by anybody and everybody is a constant source of amazement and annoyance to the layman, but there it is. What you meant, however obvious, and what you tried to convey by your manner and inflexion of voice, are of no importance whatever compared with the actual words you uttered, and you will again and again be astonished to hear every conceivable interpretation of them discussed and argued till you begin to wonder if they mean anything at all.

Never try to "score off" counsel, or to be funny at his expense or that of anyone else in court. You will not succeed once in a hundred times, and if you do it will usually earn you dislike rather than credit—a fact that you will be made to appreciate before you leave the box. The hectoring, bullying counsel is now very largely a figure of the past. If you are courteous and sincere and, above all, good tempered in the box, a "brush" with counsel will be an exceedingly rare event—provided always, of course, that you know your work and know your own mind. If not, you will have a bad time, and you will deserve it.

When under cross-examination remember that your own counsel is listening to every word and will protest immediately if his " learned friend " shows signs of going too far in his efforts to shake your evidence. You have yourself, of course, a right to appeal to the judge for direction as to whether you must answer a question, or for " protection " from any savageries of counsel. You will be well advised, however, to use this right as rarely as you possibly can. The judge is there to see that you get fair play. He knows what counsel is up to and whether his questions are admissible and his methods legitimate far better than you can possibly do, and I do not suppose he likes being appealed to for the protection he is well able to give spontaneously, any more than you or I would. Whatever appearances may happen to be, you can take it as certain that, like Yum Yum and the Moon, he is " very wide awake."

To refrain from appealing to the judge can often be not merely tactful, but also excellent tactics. In a case to which I once listened, opposing counsel so far forgot himself as to interject an uncalled-for and definitely insulting remark, during the examination-in-chief of a medical witness. The witness, well knowing that the impropriety of the remark was obvious to everyone in court, remained silent and simply looked at the jury, " registering," with considerable success, the restraint of a righteous man suffering injustice. This happy inspiration was no small factor in obtaining the desired verdict.

Mention must be made of a peculiar state of things which occurs in civil cases when one party through lack of funds, native eccentricity, thirst for adventure or some other cause, conducts his own case. The law in its wisdom holds that in such circumstances the judge must see to it that the amateur does not suffer in his contest with the professionals by reason of his inexperience, ignorance of procedure, etc. Judges have been known to discharge this duty so heartily that they have become temporary counsel for the " lone hand " party and cross-examined hostile witnesses with all the vigour of their salad days and with the added advantage of being the sole judge of the propriety of their questions and methods. I was once unfortunately involved in such a case and left the box after forty-five minutes of acute torment with several additional stains on my character, the final taunt being that I was " a partial and

unsatisfactory witness." There was, of course, only one reply : " My Lord, had counsel addressed that remark to me I should have appealed for your Lordship's protection." Unfortunately I did not think of it till the following day !

What has been said applies not to psychiatric medical evidence, but to medical evidence in general. Much of it applies to evidence of any sort, but it is very largely applied psychology of the most practical kind none the less.

There is, however, a special psychiatric question of the greatest importance which remains to be considered, namely, that of criminal responsibility. The law is not concerned with our medical views as to whether or not a given patient is of unsound mind. It assumes that every man is responsible for any action he has committed unless and until it is proved *either* that at the time he committed it he did not know what he was doing, *or* that if he did know what he was doing, he did not know that it was wrong.

You can hardly attend too carefully to every detail in the preparation of your evidence in a case in which a defence of insanity is to be set up. If possible you should see the accused at least twice, not because a second visit will necessarily yield you fresh information, but because you will certainly be reminded in court of your short acquaintance with the accused and asked if you can really speak confidently after a single meeting.

Another point to remember constantly is that you are testifying to the accused's state of mind when the offence was committed—perhaps weeks or months before the trial. You did not see him at that time, and you must therefore study his past history with the utmost care, harmonize it with his present symptoms, give a picture of the course and progress of the mental disorder from which he is suffering, fit the offence into its proper place in the story, and show by almost irresistible inference his abnormal mental state at the time of its commission.

It is a waste of time to point out in court that the criteria mentioned are completely out of touch with modern conceptions of mental disturbance. You would be quite correct in saying so, and many eminent lawyers would agree with you, but they are the law of the country and as long as they remain

so they are binding upon all concerned. They form a very interesting subject for debate, and reform of them is doubtless overdue, but if you attempt to give your opinions on them in court you will be silenced very quickly and you will simply irritate the judge, whose function is to administer the law as it stands. If your evidence is not given in accordance with these criteria it will be regarded as irrelevant and worthless, and you would have been wiser not to have given any evidence at all.

When the question of criminal responsibility arises the normal procedure is usually reversed, the onus of proof being upon the defence, and the evidence attempting to show that the accused was not criminally responsible being heard before the evidence for the Crown, which seeks to rebut this contention. Obviously the proof that a prisoner is not criminally responsible cannot be —and is not required to be—so absolutely clear and convincing as the proof necessary to convict him of a criminal charge, but the proof has to be to the satisfaction of the jury and you will realise, therefore, how much depends, in a matter of this kind, upon the way in which it is put to them by the judge in his summing up. This will depend upon the extent to which the judge has been impressed by the evidence of the medical expert, and that, in its turn, depends upon the lucidity, confidence and apparent common sense of that evidence and, above all, by its relevance to the criteria already mentioned. It is impossible to exaggerate the importance of keeping this point in mind. You are not in the box to expound a medical theory or to bring out the points which you regard as medically interesting or important. Still less are you there to indulge in scientific or psychological speculation, to summarise the latest researches or to demonstrate the newest technical apparatus. You are there to convince lay people that on a given occasion the prisoner either did not know what he was doing or else did not know that it was wrong.

It is clear to all psychiatrists, and, I think, to most judges, that many an accused person who does not strictly fulfil either of these conditions may yet be obviously insane in the medical sense. The conditions are simply not applicable to our modern conception of mental disorders, but the medical witness must accept this fact and do his best to express the symptoms of the accused in terms of them. More often than

not he will receive help from the judge in his efforts to find a form of words which will satisfy the legal view without too grossly distorting the medical one.

It must be remembered that the last word in the matter lies with the jury. In recent years juries have shown an increasing tendency to come to their own conclusions on the question of criminal responsibility independently of the judge's direction and occasionally in frank opposition to it. This tendency no doubt arises from the average citizen's feeling that "it's not fair to punish a man who's off his head" and his impatience with the niceties of legal argument upon the out-of-date criteria already mentioned.[1] Regrettable as this may be, the medical witness is perfectly entitled to convey to the jury in his evidence as vivid a picture of insane conduct on the accused's part as he possibly can, without obvious irrelevancy.

Some years ago I gave evidence at an Assize Court in the country, in a case in which a verdict of "guilty but insane" was returned. On my way to the railway station after the trial I happened to meet a member of the jury who recognised me and invited me to the local hotel for some refreshment and a discussion of the case. I thought it wiser to decline this invitation, greatly though I should have liked to accept it, so excused myself and made the remark that the verdict had been reached in a surprisingly short time. "Oh, yes," he said, "there was only one of us who seemed a bit impressed by the judge's view, but we soon put him right!"

The medical witness need not be unduly distressed if a plea of insanity which he has been supporting should fail. This will happen but rarely to a competent physician who will refuse to support the plea unless he is sincerely convinced that the accused is insane. When the plea does fail it is a comfort to remember that in every case in which a plea of insanity has been seriously put forward, the prisoner receives further expert examination after conviction, unhampered by legal criteria and rules of evidence, and strongly coloured with that humanity which is traditional in the medicine and the law of this country, and still adorns the practice of both professions.

[1] They are known as "The MacNaghten Rules," and an admirably full and clear account of them with further relevant and interesting matter is to be found in an appendix to "The Trial of Ronald True" in the "Notable British Trials" series.

Chapter 14

PSYCHIATRIC ODDITIES

It is not altogether the fault of the teacher that the medical student is sometimes slow to accept the doctrine of psychosomatic unity.

No matter how earnestly and eloquently we may plead that psychological medicine is one with general medicine, the junior student in particular is apt to feel strongly that it is nothing of the sort and that there is something very distinctive and just a little peculiar about both the subject and those who teach it.

It must be confessed that there is much to be said in support of that view. There is a great deal about psychological medicine that is indeed very queer. We need not concern ourselves to discover how these oddities became attached to the subject, but we may very profitably discuss a few of them, in a simple and informal way. They are never by any chance mentioned in the text-books, and some acquaintance with them may well prove to be of practical help to the student, as well as affording him a certain amount of innocent amusement.

In any account of psychiatric oddities, pride of place must certainly be given to the average "relative," above all to the parents of neurotic and delinquent children. Faced with these, I have seen even a Sister who could deal with platoons of "ordinary" relatives in her stride, so to speak, retire discomfited. They are diagnosable at sight, the moment they enter the out-patient department or the consulting room, and their central trouble is their inability to learn that it is the patient and nobody else who has come to consult the doctor, and that he cannot treat two people—least of all two neurotics—at once. I once invited the mother of a delinquent child to tell me about him. "Yes," she replied, sitting down in her chair with the glad joy of battle in her eyes, "I'll tell you all that his father and I have had to endure for the last six months." I was indiscreet enough to say, "No, don't do that, just tell me

about the boy," and the consultation very nearly broke up in disorder.

Of course the " relative" difficulty is more acute in psychiatry than in any other branch of medicine, chiefly owing to the fact that the natural anxiety of the patient's relatives is almost invariably accompanied by an extreme degree of ignorance and fear. It is generally agreed that a maternity hospital is the right place for a patient about to have a baby, and it is considered excellent practice to send a patient suffering from scarlet fever to a hospital for infectious disease. Five times out of six, however, the mere suggestion that an insane patient should go to a mental hospital is greeted by all concerned, save the unfortunate specialist who made the suggestion, with outbursts of resentment and attempts at " evasive action " which would be laughable were they not so pathetic. Here, indeed, is a psychiatric oddity which the thoughtful student would do well to ponder.

Closely connected with this is the good old slogan of " Every man his own psychiatrist." This is so universally accepted that one can hardly call it more than a mild eccentricity, but it leads to some startling situations, nevertheless. You may take it that nine times out of ten your wildest theories will be listened to with deference and respect, your craziest opinions accepted, and your most fantastic instructions followed to the letter, provided that they are concerned with a patient's heart or tonsils or gall-bladder, or indeed any of his bodily organs or functions. But the moment you enter upon the infinitely more specialised and complicated field of psychology or psychiatry and suggest that a patient's way of life needs reorganising or that his psychological outlook is faulty in some respect, some hitherto submissive relative will instantly turn upon you with : " Ah, no, Doctor ; you're wrong there ! I don't agree with you at all. Now, in *my* opinion . . . . . ." What happens next depends on whether or not you have the courage to remind the relative that, after all, it is your opinion on the case, and not his, that is being sought.

The chief interest of this very common situation is that out of it there very often arises one which has some claim to be considered the *ne plus ultra* of oddity in a mad world—namely, the " unprejudiced opinion " gambit. Mr. and Mrs. Smith,

let us say, have been told by their practitioner, Dr. Jones, that their adolescent son, whom he has known since infancy and has recently been treating for influenza, is showing some rather strange and disquieting symptoms. There is nothing very definite, but the doctor is not happy about it, and advises that a psychiatric opinion be obtained. The parents have always thought that Dr. Jones was a bit fussy, and of course everyone knows that he has never been quite the same since he took up psychology a few years ago. They explain away the symptoms and the matter drops, but some weeks later, just as Dr. Jones's lapse was being forgiven and forgotten, the same advice comes from the boy's headmaster, coupled with a tale of idling, pilfering, sexual misconduct and so forth at school, and a polite but firm intimation that "unless his behaviour shows a marked improvement . . . . . etc." Dr. Jones is summoned and asked whether he was suggesting that the boy was "going mental," or whether he agrees that it is "just nerves," for which he should have prescribed "a nerve tonic that time last year when Willie threw the cat out of the window." The upshot of a long discussion on these recondite points, into which we need not enter, is that Willie is taken to an eminent neurologist. The neurologist says that there is no organic disease, but there is certainly serious psychological disturbance, and as that is not his province he strongly recommends that a specialist in psychological medicine be consulted.[1]

But Mr. Smith has had enough of all this collusion. He knows what these doctors are. Dr. Jones is prejudiced, the neurologist is steeped in prejudice, and the school authorities are prejudice incarnate. He will consult a psychiatrist, but he will see to it that the man comes to the case with an open mind. In other words, he will see to it—and, in fact, he very often does see to it by means of an astonishing series of elephantine deceptions—that the psychiatrist is deprived of hearing a single statement of fact or opinion from the practitioner who has known the boy from birth, from the school authorities who have seen and taught him daily, eight months in the year, since he was fourteen, or from the trained colleague who has just made an expert and exhaustive examination of him. All these

[1] "The characters in this story are entirely imaginary." No reference to any living person is intended.

people have one common aim in the matter—the boy's welfare. Why they should be suspected of conspiring, in some sinister fashion, to poison the mind of the psychiatrist by telling him their opinions, and why the psychiatrist should be regarded as certain to abandon his opinions should they differ from those of his colleagues, are oddities which the student may justifiably think are beyond the wit of man to explain.

As a rule it is useless to tell Mr. Smith that the information to be derived from these sources would be of incalculable help. He knows little and cares less about the difficulty of getting a real grasp of a psychiatric case at a first interview. Besides, the psychiatrist is not to be entirely without assistance in arriving at his unprejudiced opinion. Mr. and Mrs. Smith are coming with the boy. He has been told that they are going to visit a doctor friend of Mrs. Smith's who wants to see how her bronchitis is getting on. He has been told this because it would be a great "shock" to him to be told the truth. How to deal with the "shock" he experiences on discovering that he has been told a stupid lie is, of course, a matter for the psychiatrist. Anyhow, Mr. and Mrs. Smith will have a little talk with the psychiatrist first, at which they will put "the true facts of the case" before him, and, incidentally, make sure that he does not learn any more than they think it good for him to know. The crowning oddity in this nightmare of oddities is that any parent could propose, and any psychiatrist could agree, to leave some nervous, bewildered, frightened adolescent alone in a strange waiting-room, while the Olympians talk about him behind his back in the remote austerity of the consulting room of an unknown doctor to whose presence he will soon be summoned.

Though the above tale is a composite picture, each separate detail is fact and within my personal experience. Many of the points—such as, for example, Mr. Smith's "shock-avoiding" trick—are instances which could be multiplied indefinitely, each showing its own individual degree of imbecility. I have had to explain to a sulky and antagonistic adolescent, in the presence of his embarrassed parents that I was not really Dr. Green, who happened to be in the house by accident, but that the name he had seen on the door-plate was my own. I have also had to deny that I was an old college friend of a

well-known headmaster, and to disclaim an expert knowledge of mathematics. To have to accomplish such tasks as these before entering on the most difficult kind of consultation known to medicine is a supreme psychiatric oddity. A couple of practical hints may be interpolated here, before we proceed to consider other oddities of this strange specialty. Never agree to conceal your name or your profession from a patient. All truth is not good to tell, and if you should ever become a psychiatrist there may be occasions when you will be wise to keep quiet about it. But do not lie about it if directly questioned, and when you admit the fact try to do so as if you were proud of it.

In private practice make it a rule to see the patient first and alone. This holds for every patient between the ages of 5 and 75 who is able to walk, though of course there are many cases in which half a minute will suffice to show that a relative or friend should be asked to come in. But the point is that every patient who has come of his own accord to consult you privately should be told that he is entitled to the two great privileges of a patient, namely, the right to have first innings and tell his own story in his own way, and the assurance that nothing he says will be repeated outside the room without his consent.

But relatives are far from providing all the oddities of psychiatric practice. The patients, of course, do so *ex officio*, as it were, so it would be hardly fair to include them in this survey at any length. Nevertheless, a true understanding of psychotic patients and a human approach to the study of their symptoms is becoming steadily rarer, because time spent in working, playing and living among them is becoming more and more regarded as time wasted. It is a minor oddity, by the way, that the devastating effect of this view upon the clinical powers of our neo- and neuro-psychiatrists is not more frankly and generally admitted, but our present concern with the matter is that those without experience of real mental hospital life can never hope to see and study some of the most remarkable and important symptoms in all psychiatry. They also miss many situations and episodes of the most fascinating human and medical interest.

It will doubtless surprise some students to learn that the game of chess is very popular in many mental hospitals, and that a high degree of skill is shown by many patients. The most remarkable game I ever witnessed was the critical one in the annual chess tournament which was a very popular feature of the social life of a certain mental hospital. One of the players was a robust person of formidable appearance, with a generous share of that extreme irritability which is an outstanding feature of the epileptic character. He was a good sound player, but more than once had had to be called to order for expressing his views about the other players, the hospital, and life in general, in good old Anglo-Saxon of an unconventional kind. His opponent was an undersized, spectacled, scholarly little gentleman, with an intense inferiority sense, a chronic nervous giggle, and an infuriating chess-habit of picking up a piece as if to move it, waving it about, and then replacing it with a wan and apologetic simper. Each disliked the other cordially, and it was an unfortunate chance which had brought two such incompatible personalities together for the "needle" game which would have an important bearing on the final results. I undertook to umpire the game, and informed the combatants beforehand that it was to be played in silence and in strict accordance with the rules. In particular I pointed out that the use of any unparliamentary expression would mean instant disqualification, and that once a player had touched one of his pieces he must move it.

With these points clearly understood, the game began before a large company of spectators. As it proceeded, signs of strain became apparent on both sides, and I congratulated myself on my forethought in laying down such definite regulations. My robust friend was labouring under strong emotion. Beads of sweat appeared on his forehead, so great was his effort at self-control, and he was clearly only restrained from bursting into lurid comment by the fact that he was having distinctly the better of the game and realised that only an expression of his feelings could rob him of victory. He deserved credit for his control, because his opponent's antics would have irritated the most phlegmatic. He fidgeted, giggled, gasped, whispered little apologies, sat on his fingers, clasped them, chewed them, and tied them in his handkerchief

in his frantic struggles to avoid touching a piece prematurely. At last his opponent left him a tempting but fatal move. He reached to the board with a delighted giggle, but as his fingers touched his piece (it was the Queen) he saw the trap, drew back his hand as if it had been stung, looked up to the ceiling, smiled gently and gave a very creditable imitation of a player who has not even begun to think about his move. But it was too late. His opponent's self-control had given way, and an hour's pent-up epileptic fury burst forth in an ear-shattering roar of " MOVE IT, you b . . . . .! ! ! " The gentleman addressed gave a convulsive shudder, lost his balance and fell on the floor, overturning the chess-board in his descent. He picked himself up, uttered an unintelligible whinny and fled from the room in terror. His adversary also left, by request and by a different exit, and as soon as I could make myself heard I declared the game a draw.

This human little interlude leads naturally to consideration of some psychiatric oddities for which ultimate responsibility must be laid at the door of psychiatrists themselves.

It is odd that the tendency to classify and generalise, which is natural enough, and often helpful and necessary in medicine, should become a craving, not to say an obsession, in the one branch of medicine in which it is most obviously futile. It is generally admitted that the conduct of any stable and " normal " individual in given circumstances is rarely easy to foretell with certainty, and may falsify the oldest and soundest generalisations about human nature in the mass. Such falsification is infinitely more probable when one is dealing with neurotic or psychotic patients, yet it is in this very field that categorical statements and " universal laws " are propounded with unfailing persistence and dogmatism. It is agreed that all sane psychotherapy is founded on the fact that each patient's psychological make-up and reactions are peculiar to him alone, and we talk a very great deal about " individual psychology," but in the same breath we talk about " reaction types " and " psychological types " and " brain patterns " as if mental life in sickness or in health fell into one or other of a few well-defined groups, and was fully explained by the general characteristics of the group to which it happened to belong. It is in that last clause that the danger to the student lies.

There is nothing wrong or inaccurate in such phrases but they are sadly inadequate. The student should resist the temptation to think that the matter is quite so simple as that, and should remember that there are as important psychological differences among people of the same " reaction type " as there are ethnological ones among people of " the dark-skinned type."

Taking it all over, the student would be wise to avoid the use of the word " type " as much as he possibly can. It is a thought-saving device which grows upon one like the cigarette habit, and the word is certainly much more at home in current R.A.F. slang than in a hospital ward or out-patient department. Some years ago, just after I had conducted a quiet and fairly successful campaign to exclude the word from some classes I was holding, a patient was sent in for demonstration, with a note from an enthusiastic junior assuring me that this was a " typical type," of something which I have mercifully forgotten. I am not very sure what a " typical type " really is, but perhaps I shall one day meet a typical " typical type," and then I shall know.

It is in the written word, even more than in the spoken, that sweeping generalisations and vague references to types tend to flourish unchecked, particularly in papers on psychological subjects. If every medical student were to make—and keep— a resolution that he would never, in the years to come, refer in a paper to a patient or patients whom he had not personally seen and examined, the medical journals would be pleasanter reading, the cause of science would be advanced, and the world would be a happier place. This oddity of writing about unknown patients takes various forms, and its main object is rarely the advancement of knowledge. A popular method, which by an ingenious sophistry often calls itself research, is to obtain, or get some industrious friend to obtain, all the available statistics about some more or less well-defined section of the community. These statistics may deal with anything about which information happens to have been collected, such as the number of sound teeth at the age of 40, the number of times divorced, the number of times in hospital, whether corporal punishment was administered in childhood, whether homosexual thoughts have ever been present, etc., etc.,

ad inf. The source of the information is often that remarkably unreliable one, the questionnaire. Add a few facts about the conditions of life of the " cross section of society under survey," do a little arithmetic, append a summary and conclusions, and " here we have a play fitted "—or something very like it.

Some years ago an ingenious and ambitious young graduate spent six months in a special hospital for nervous disorders. She got a secretary to extract from its records the name and address of every patient during the previous five years to whom the diagnostic label of " Hysteria " had been attached. She then drafted a circular letter to be answered by the ex-patient, or, if that were impossible, by the next of kin, enquiring if the ex-patient was quite well, improved, in *statu quo*, worse or dead. The replies were sorted by a competent secretary and the result was an M.D. thesis entitled " Prognosis in Hysteria." My advice that this piece of " research " be rejected caused considerable ill-feeling.

Theoretical papers on medical or psychological subjects are a totally different matter, and of course it is very proper to quote, or procure, statistics to confirm some theory or illustrate some point, but to write a paper, on, for example, " The causes of anxiety-neurosis in deep-sea fishermen," or " The recovery rate from psychosis in Peru " if one has never been beyond Greenwich, is not merely unscientific ; it is stupid.

In psychiatry there is a good deal to be said against writing even about patients one has seen, unless one is prepared to write about them as individuals and to remember that, especially to the student studying a text-book, each patient is a law unto himself. A detailed account of a patient's conduct and symptoms, written from a clinical angle to illustrate some particular point, may be quite helpful, though it is but a poor substitute for a clinical demonstration, but the average " case-histories " with which most psychiatric text-books are interlarded must surely be an incomprehensible and intolerable weariness to most students. If a writer says that a patient had incontinence of urine and lay in bed yelling " murder " every ten seconds, we can all form a picture of the situation he is describing. But if he says that a patient was of the " affective reaction-type " or was " an aggressive psychopath," my conception of those expressions is probably quite different from

the writer's and I am perfectly certain that to the average student they convey nothing at all.

If the past is a guide to the future, we may resign ourselves to the fact that no self-respecting book on psychological medicine appearing in the next three or four years will be without its chapter on " Military Psychiatry." After that we shall hear no more about it—a prospect which we may contemplate with equanimity for reasons into which it is needless to go.

The above notwithstanding, this volume contains no chapter on the subject, and, that being so, it seems hardly fair to comment upon its oddities, which are numerous and striking. I venture, however, to give at some length one " case-history " which illustrates several of the points discussed in this book, and in particular its central theme that psychiatry is inadequate and largely meaningless unless it adds to its scientific background a human approach to each individual patient. The story is certainly full of oddity, but most of it was contributed by the patient. I may be thought to have added my share, but I think we may hold military psychiatry blameless in the matter, which never came to official notice. Besides, it is a story of the prehistoric skirmish of 1914–18.

The patient first came to my notice at a base hospital in France in 1917, when he was admitted to my special wards along with several other severe cases of " shell shock," as it was called in those dark ages. He did more than come under my notice ; he obtruded himself upon it by reason of the severity of his symptoms which included apparently profound unconsciousness, spasmodic twitching of the face and limbs, and an occasional gasping sigh. I studied his medical card which had accompanied him on the ambulance train, and was struck by the fact that while it did not give a very accurate account of his symptoms (a thing quite understandable by itself), it did give a brief but admirably correct description of those of a patient a few beds away who had come in the same train. The two cards, in fact, were almost identically worded, and it occurred to me that the one might have been copied from the other. A closer inspection gave me the strong impression that my patient's card was " phoney," and a re-examination of him convinced me that his symptoms were also.

Ignoring his apparently complete " inaccessibility " and the shakings and groanings with which he punctuated my remarks, I told him in a quiet, conversational tone that if he cared to make an instantaneous recovery when I had finished speaking, I should keep him in my mental ward for a fortnight, send him to a convalescent depot in France thereafter and so back to his unit. On the other hand, if a miraculous recovery did not take place I should mark him for immediate " Duty," the result of which would be a court martial, to which I would have him carried on a stretcher if necessary.

An embarrassing half-minute followed while he considered this highly unprofessional bargain. He then opened his eyes, smiled brightly and said, " All right, Sir, I'll get well at once ! " He then explained how he had got hold of a medical card, " jumped " the ambulance train, copied out the medical history of his neighbour " with a few simple alterations," malingered his symptoms, and had, by an amazing run of good luck, " got away with it." He also told me that his civil occupation was to frequent race-courses, where, with the aid of an umbrella, a pack of cards, and a thimble complete with peas, he made quite a satisfactory living, in association with some more than doubtful bookmakers ! Far from bearing any ill-will, he expressed gratitude for the arrangement made, and admiration for my " sharpness." He demonstrated this good feeling in practical fashion by inviting me to come to the ward " of an evening " when he would show me " one or two little tricks." I accepted the invitation and studied under him nightly for just over a fortnight. He was an astonishingly clever card-conjurer as well as an excellent teacher, and I owe to our seances a certain facility in the three-card trick and other trifling feats of legerdemain, which has not altogether departed even yet, and which has been a source of much amusement to me—and even, occasionally, to others. He was a friendly and cheerful citizen,[1] and when we parted, never, as I imagined, to meet again, it was with mutual expressions of affection and regard, though as he went so far as to state his opinion that I was " a gentleman " and had " played the game," I felt unable to return the compliment in so many words and had to find an alternative formula.

[1] A safe word.

The story has a sequel which occurred in 1936—nineteen years later. On entering the out-patient department at Hospital, I noticed a small, highly amused crowd of nurses and students in the corridor. As I turned into my room I was interested to hear a voice proclaiming : " Wot we all said was, ' You can't swing the lead wiv Capting Y,' " followed by a burst of laughter.

Not having heard myself so referred to for many years, I joined the party and was rapturously greeted by my old friend. He had changed his occupation and now earned his livelihood by playing an unusual-looking musical instrument, which he was carrying tenderly, outside public-houses in the district. In the course of his activities he had heard my name mentioned as being at the Hospital, and had looked in on the chance of seeing me. His cry of " Capting Y ! You remember me, Sir : 'im that taught you the card tricks ! " is a pleasant memory. Even more pleasant is the recollection that after a long exchange of reminiscences I had the greatest difficulty in persuading him to accept the wherewithal to purchase some refreshment in which to drink my health, but whether this was due to native good feeling or to the fact that he had already taken fully as much as was prudent, I do not know. I like to think it was the former.

Chapter 15

THE WORD "GO"

THERE has not, one imagines, been a time within living memory when the intolerably overcrowded state of the medical curriculum was not the subject of complaint and controversy. A few of the more senile among us can, nevertheless, recall the days when at one or two of the more advanced medical schools some teacher, unorthodox to the point of eccentricity, was in the habit of devoting part of his course of lectures—usually the last half of the concluding one—to a homily on "medical etiquette." He sometimes even referred to "medical ethics."

This practice, if it can be so called, has long since died out,[1] and the student of today is left to grasp the niceties of medical etiquette, or such of them as remain, by a process of trial and error, with the general principles he learned at his mother's knee as a basis and background. Unfortunately, statistics show that the results of learning at one's mother's knee are not what they were and that the practice of avoiding error by refraining from trial is becoming increasingly prevalent. A few days before writing this chapter I had a rather depressing conversation with a very recently qualified young man from one of our most famous medical schools. He told me that such subjects as the conduct of practice, professional etiquette and custom, and the principles and traditions governing the doctor's relation to patients, colleagues and the public had never been so much as mentioned from beginning to end of his course.

It is perfectly true that nine-tenths of medical etiquette is simply a question of common sense plus good manners. But even if we assume that all medical students possess these qualities in abundance, we are none the less to blame if we let them leave their medical school without a single word of information, warning or practical advice about their conduct in the profession. Common sense and good manners in combination will certainly prevent a man from committing "infamous"

[1] I am told that it still survives—or has been resurrected—at one provincial medical school.

professional conduct and from getting into really serious trouble, but they cannot give him a knowledge of the various customs and practices which are peculiar to medicine, or spare him from the consequences of the lack of such knowledge. He will never make a fool of himself, but his lot would be infinitely happier if he had the opportunity for a few words with someone who knew the ropes, before he plunged into the strange new world of medical life and practice. This will hardly be questioned by any who can recall their early days or weeks at school or university, or in any of the Services—and there are probably more pitfalls in medicine than in any of these, for the uninformed.

It may well be that the curriculum ignores medical ethics and etiquette because these subjects, though apparently superficial, have a way of leading on to questions of character, outlook and psychological adjustment, of which, indeed, they are the outward and visible signs. Those are deep and disturbing matters which cannot be summarised by the teacher in a set of rules, or " learned " by the student as he learns the anatomy of the brachial plexus. In fact, unless we sheer off very quickly—no, we are too late ; it is indeed our old enemy " the psychological factor " making yet another of his Cheshire-Cat-like reappearances, complete with grin.

Considering what a hopeless mess we make of that factor in our patients, it is hardly surprising that so many of us ignore it altogether in our students. And yet, our students, like our patients, are human beings, not machines or glorified test tubes. The vast majority of them are adolescent human beings, at the most impressionable and receptive stage of their lives. Our business with them is to fit them for a profession in which breadth of mind, insight and human understanding will stand them in as good stead, to put it mildly, as book-learning, with the patients whom they have to restore to bodily health and mental stability. Is it, therefore, fair—is it even decent—to limit our teaching to the same old mechanical so-called scientific approach, to exalt it as if it were the one and only thing necessary, and to pay no attention whatever to the outlook which the student is developing or the philosophy of life which he is attempting to formulate ? If we ignore this part of his general education which is so vitally connected with

his medical education, there is surely a strange insincerity in our common complaint that the standard of his general education is too low when he first comes into our hands. The less satisfactory that standard is, the more incomprehensible becomes our procedure of turning him out in a few years, "qualified" to deal with the physical, occupational, social and sexual difficulties of others, without having so much as ascertained, far less strengthened, modified or clarified his own attitude to these problems as they present themselves to him.

There is little doubt that in due course a Strong Committee on which all Branches of the Profession are represented will skim off the superficial and teachable part of medical ethics from the underlying and vitalising "psychological factor," and will see to it that some instruction is given by a suitable expert to those about to graduate regarding the problems of conduct which the newly qualified doctor has to face. Helpful though this may be, it will leave untouched the very much more important matter of the mental attitude and outlook of the young person who is about to enter, not on the practice of medicine, but upon the student curriculum. To teach him about medical etiquette is one thing, but to talk to him about his personal outlook on life and work is a very different one.

There would, I fancy, be little competition among teachers for the task of dealing with this matter. A majority of both teachers and taught would certainly regard any verbal discussion of it, which was not so formal and impersonal that it could be made a gramophone record, as something akin to indecent exposure of thoughts and feelings and an unwarrantable intrusion upon the rights and privacy of the individual. As for the unfortunate teacher who attempts to write on such subjects, the reviewers have a kind of special commination service all ready for him. If he ventures a private opinion he is wandering away from his scientific business; if he rashly introduces a personal reminiscence he stands convicted of senile maundering; and if he is mad enough to give a word of advice, or even to refer to questions of character and conduct, that awful word "sermonising" damns him beyond hope of redemption in the mind of every true Englishman.

And yet . . . . . A few weeks ago two junior students

asked me to " explain about ideals " in a lecture. Were they signs of neurosis and was it silly to have them and to try to live up to them? Two days later another student commented on the " dualism " evident to him in a lecture I had given, and was anxious that I should expound the matter more fully. It is by no means certain that these gentlemen had a very clear idea of what they were talking about, but that merely increases the urgency of the question—what, if anything, are we going to do about this situation? Have we anything worth saying to say to the student at the very beginning of his course—from the word " Go," so to speak— and, if so, have we the courage to say it?

My answer, though far from heroic, has, perhaps, some slight merit of ingenuity. There can surely be no harm in impressing on students the necessity for adopting the scientific outlook from the word " Go." If that is granted, it is clearly quite in order to mention a few of the things which it is universally agreed that outlook implies. That is all I have done in the rest of this chapter, from which I have expunged to the best of my ability any unsupported private opinions, any personal reminiscences and any tendency to " uplift." I admit one lapse towards the end of the chapter, when I venture to suggest the necessity and the means of broadening the purely scientific outlook. My excuse for it is simply that it is only a very little one.

We have Wordsworth's assurance that it was bliss to be alive and " very heaven " to be young in the " dawn " which was the French Revolution. It is, I think, debatable whether it was really better fun being alive and young in that dawn (or any of the long series of irritatingly abortive " dawns " which have succeeded it), than at any other time. Be that as it may, it surely must have been a glorious thing to be a medical student in, say, the " naughty nineties " and the decades immediately preceding and following them. There was no faint illumination of the darkness by the uncertain light of any dawn; the darkness had been banished forever and replaced by eternal day as in the transformation scene of a pantomime. This feat had been performed once for all by the Fairy Queen, Dame Science, whose torch or arc lamp shed a brilliant if rather cold and artificial light over a very remarkable scene.

Those were the days ! The steady and remorseless glare revealed all secret things, so that no illusions remained and practically everyone knew practically everything worth knowing. The lot of the young men of the period was indeed enviable. They knew all the answers, or at least their teachers did, and there were so few problems left to solve that instead of wrestling mightily in spirit they could survey present, past and future with equanimity and devote themselves to formulating crisp and clear expressions of ultimate truth in its various aspects from the abundant material at their disposal.

And what material it was ! Its old-world fragrance still lingers among us. " A fortuitous concourse of atoms " ; the description of " the living self " as " a series of events in space-time " ; the legendary anatomist who said " I have dissected a thousand bodies, but have never seen the soul " ; a proverb about there being one atheist in every two doctors ; a pretty illustration about the flame of a candle ; the helpful statement that " the brain secretes thought just as the liver secretes bile " ; faithful dealing with that ignorant and presumptuous scientific treatise, the book of Genesis ; witticisms about monkeys and missing links, and much else, liberally sprinkled with the *obiter dicta* of Darwin, Huxley, and German philosophers, and ballasted with " the facts of geology."

A pleasant time was had by all. Nor were the arts altogether neglected, though the average medical student of the day had little time or use for poetry. It was quite permissible, however, to " quote Swinburne." This meant " counterfeiting the deep tragedian," and mouthing a stanza or two from *The Garden of Proserpine.* I do not think medical students were familiar with any of the poet's other writings, except, of course, the single line : " Thou has conquered, O pale Galilean," which was in great favour as the slogan of the disillusioned cynic of twenty. William Ernest Henley, too, was known on the strength of his head having been bloody but unbowed, and for no other reason.

A topic of outstanding and unfailing interest was the "Science versus Religion " controversy. Science had known for quite a time that the whole crazy edifice of Religion should have collapsed long ago and now there was keen competition for the honour of delivering the final push which would send it

crashing to utter destruction. Most " advanced " people were as certain of its impending overthrow as are their grandchildren—the new world " planners "—that next year will see the banishment of poverty, squalor and all social evils.

It is the inalienable right of young men at a certain stage of development to spend a good deal of time with their feet higher than their heads expounding the secrets of life and the universe to each other. This is as it should be, but the fact that they are still hard at it today, undeterred by certain difficulties concerning the quality of beer and the price of tobacco, would seem to show that by some regrettable mischance Science's lighting system failed to function quite according to plan and that darkness has fallen again with a few minor points still remaining to be cleared up. The glib and confident pronouncements of the Science of forty or fifty years ago have proved to be sadly disappointing and incomplete, and the young devotee of Science is not going to have such an easy time of it as his exuberant predecessors. The fact remains, nevertheless, that in spite of all that has happened the very first essential for the medical student still is that he should possess the scientific outlook and that he should understand something of what that phrase really means.

It means—if I may now address myself to an imaginary class of junior students—that you must be devoted to the spirit and service of Science. One may indeed say that you should be wedded to Science, but it must be holy matrimony and not a mere flirtation, still less a vulgar intrigue. In other words, you must take her, if at all, for better or worse, and you must be prepared to find that the partnership will turn out very differently from what you expected. The more you know about her before the wedding the less unpleasant will your surprises be after it. She is an implacable sort of lady who will not change her character to suit you, so it is only elementary prudence for you to consider in good time not merely what you expect from her, but rather what she will demand from you.

Her demands are few, but they are by no means what you might have expected, and it may seem surprising to you that they have nothing to do with intellect or ability but are solely concerned with certain qualities of character. It is startling to realise that Science has apparently fallen into the same

condemnation as the public schools by putting character before intellect—so startling indeed that it has led to many a broken engagement and some divorces—but it is profoundly true nevertheless. She has, of course, no use for nit-wits, and the better the brains you possess the greater man of science will you doubtless be, but unless you have the qualities of character she demands you will never be one of her men at all, whatever the splendour of your intellectual equipment.

Her first demand is for that very unfashionable quality, humility. She has learned a good deal herself in the last half century and is no longer the aggressive and flamboyant lady of the " naughty nineties." She has never been quite the same since modern physics—perhaps her favourite child—broke away from parental control and actually established a nodding acquaintance with those terrible outsiders, philosophy and metaphysics. To go that length herself would have been to sign her own death-warrant, as Macneile Dixon points out, but to keep the family together she was forced to acknowledge the existence of such persons on the fringes of her domains, and has had to endure the sight of one after another of her brood making their acquaintance. " Scientific " psychology alone remains faithful to the family tradition and the lost cause and trots patiently along, more royalist than the king, much as Mussolini, in Mr. Churchill's immortal description, trotted beside Hitler.

Now all this was very upsetting, and though Science is not going to discuss the matter with " each new-hatch'd, unfledged comrade," she is more sensitive than ever to anything approaching cocksureness in her lovers, and knocks it out of them remorselessly in small matters as in great ones, " from the word Go."

" I don't know " is the beginning of the language of Science. It is not a confession of ignorance on a point of fact, such as an ill-prepared schoolboy might make. It is the expression of an attitude of mind, a humility which shuns the arrogant " I know all about it " and says simply and without shame " such knowledge is too wonderful for me ; it is high, I cannot attain unto it." Needless to say, this is accompanied by the resolve to go patiently onwards until one *has* attained unto it, or rather has attained as near to it as one can in a lifetime. Meanwhile

one becomes progressively less disposed to dogmatise about it, not because one is unaware of one's increasing knowledge and experience, but because one becomes painfully aware, the more one studies any subject worth studying, of one's abysmal ignorance of its vast unexplored depths. This is as true of bacteriology as it is of astronomy, but very particularly does it apply to the multitude of subjects to which the scientific method is not the only, or the best means of approach, to say nothing of those to which it is not even a valid means of approach.

Even in these days a junior medical student is quite apt to suffer from admiring relatives who do not shrink from publicly inviting him to announce Science's latest word on such matters as the value of pain or the possibility of thought transference, on the strength of his having spent six months in the dissecting rooms. Apart from such painful situations, there is the quite natural inclination to put the local padre right about spiritualism or the future life, or to deal faithfully with the local crank about vaccination, vegetarianism or Christian Science. All temptations of this kind should be strenuously resisted. By all means discuss these matters to your heart's content in an unofficial way with your friends and colleagues, but don't bring Science into a brawl. Even if you had the necessary experience and knowledge to speak with assurance, these matters are not amenable to logic and reason. An experienced controversialist will make mincemeat of you, and the repute of yourself and your Science will suffer grievously. If you devote yourself to listening much and saying little, however strong your opinions, you will in due course become qualified to make *ex cathedra* pronouncements—and will by that time have become too good a man of science to wish to do so. I imagine that an average student, looking back over, say, the past year, can recall few if any occasions on which he regrets having kept silence, but I am certain that he will have no difficulty in remembering any number on which he is sorry he spoke.

It may be said by way of digression that the acquiring of increasing knowledge and experience in some branch of study coupled with an increasing realisation of one's ignorance, is an extremely gradual and almost imperceptible process. Nothing seems to be happening until, as William James put it, you

wake up one morning to find yourself one of the competent ones. There are few more interesting experiences than to find oneself, as an examiner, sitting in the same room and at the same table (but on the opposite side) where one had sat fifteen or twenty years earlier, as an examinee. One tends to feel that one knows very little more than one did in those days, but that the candidates know very much less !

Science's second demand is for intellectual honesty—for sincerity. A blind eye turned upon one miserable leucocyte in a blood count, or the addition of an imaginary one, may change a long and wearisome calculation into a simple one. It seems almost asking too much of human nature to refrain from this innocent " fake " or a myriad of similar ones, particularly if you convince yourself, as one always can, that it is not going to affect the patient's welfare or treatment in the slightest, that " they " know the answer already and only wanted to give you something to do, that it wasn't really your case anyhow, that an approximate or average result is all that is wanted, that they aren't really interested and won't ask about it, and that you really were far busier than anyone realised. The answer is that even if all these rationalisings were sound and relevant, instead of having nothing to do with the matter, your true lover of Science could not descend for a moment to such devices. It simply would never occur to him to do so. He would as soon think of falsifying a cheque in his favour. This same passion for truth would prevent him from suppressing facts which seemed to contradict a cherished theory, and from supporting his views by arguments which he knew to be plausible but unsound. It would seem that most of us have a long way to go before Dame Science will be proud to admit us of her crew.

Now this intellectual honesty becomes a quality of character and cannot be assumed when at our work and discarded in our everyday life, in favour of a more easy-going and less uncompromising attitude. There is nothing whatever " wrong " in such an attitude, and it is by no means suggested that anyone who does not possess the scientific outlook is a potential pickpocket. On the contrary, such a person may very well have as full, as happy and, indeed, as useful a life as any scientist, to say the least. In certain professions, such as those of politician,

thing, there is always the chance—just the chance—that you may one day find a new and original and correct answer to something for yourself. In that case you will graduate into the ranks of the immortals, your place therein being determined by the nature and value of your discovery. Even if it be of small value, to have made it will at least have been a completely new and startling experience.

But the best and simplest way of avoiding the weariness of spending your life in verifying and applying other men's work is clearly to direct your attention, for part of your time at least, to problems of which no scientist has as yet offered a complete and satisfactory solution. They will be specially difficult problems, of course, but nobody has got much of a start on you, and your chance of finding a solution is as good as the next man's. Fortunately such problems abound and, still more fortunately, you can tackle them in the ordinary course of your life and medical work, because they are the problems of the behaviour of the people you meet every day and of your human intercourse with them. Half an hour's talk with any of your fellow beings, be they strangers, patients or friends, can provide material for months of study and research and can furnish a multitude of questions to which Science has not, so far, offered the ghost of a real answer.

She has failed to do so because of the fact, already mentioned, that there are many problems to which a purely scientific approach is always incomplete and sometimes quite invalid. These " human " problems fall into that group. If you want a quiet hint as to where Science goes wrong in her approach to these problems I may perhaps say, without disloyalty to her, that, like the modern social reformers, she fails to see that each human individual is a unique phenomenon which has never happened before and can never happen again. She, and they, persist in attempting to classify, to catalogue and to generalise over human personalities as if conducting a large scale chemical experiment. You have been warned.

If, therefore, you want to have a hope of succeeding where she has failed, it is clear that you must add something to your scientific outlook. For your particular profession—the science and art of medicine—to possess nothing more than the scientific outlook is almost as bad as not possessing it at all.

Unless you enlarge and expand it (without, of course, transgressing it or doing violence to it) you are in danger not merely of having an incomplete and limited viewpoint but of falling a victim to what G. K. Chesterton described as the supreme lunacy : not the loss of your reason, but the loss of everything but your reason.

What you should add to your scientific outlook to avoid this calamity is a matter we are precluded from discussing at the moment by the undertaking given earlier in this chapter. I venture, however, at the risk of breaking that gentleman's agreement, to make one modest suggestion. I think that the most useful single ingredient to add to the scientific outlook is, without doubt, the capacity for wonder. The scientist must ask "Why does this happen?" unemotionally and without consideration of values, no matter what the problem before him, but he will be no less a scientist and a far more complete man if he can also say of the rising of the sun, the growing of the flower, the beating of the heart—"it is wonderful, beyond telling, that these things happen."

That is not unscientific. What is unscientific is to make technical terms a cloak for ignorance, to take descriptions for explanations, and to "darken counsel with words." "It is purely a matter of surface tension." "It is simply a matter of protein metabolism." "It is merely a matter of molecular vibration." Is it really? So now we know all about it, do we? Or do we? I rather think not.

But even if—submerged by a flood of polysyllabic jargon—you think you have found "a satisfactory explanation of certain interrelated biochemical phenomena, hitherto inadequately categorised," you will enhance your achievement and do no harm to your scientific repute if you are able to wonder at the phenomena you have so successfully elucidated. If that ability is but a frail plant in you—a merely tepid personal interest—you should do what you can to encourage its growth into respect, enthusiasm and finally wonder, rather than let it fade through indifference into boredom. The scientist who has come to the reasoned conclusion that there is nothing to wonder at is surely the lineal descendant of that well-known Old Testament character the Fool, who hath said in his heart there is no God.

I said that the capacity for wonder should be added to the scientific outlook, but I think that the really great scientists possess that capacity and that outlook in combination from the very beginning—" from the word Go." It is at least a harmless fancy that perhaps the researches which have led to Science's greatest triumphs were initiated by a Galileo or a Newton or a Harvey saying, not " I want to know why," but " I wonder why ? "

You can be confident that a combination of the reasoning mind with the experiencing mind—science and wonder—comprehension and apprehension — will enable you to get away with something like a flying start [1] when the word " Go " invites you to plunge into the student curriculum, medical practice, the duties of some responsible post, or any of the adventures which lie ahead. There is, however, a final and special reason why you should earnestly covet that combination. We have regarded the word " Go " as an invitation to start something, and so it will be, every time you hear it, except one—the last one. On that occasion it will not be an invitation to start anything : it will be an order to stop everything. That, at least, is what Dame Science will tell you. After all these years (I hope) of holy wedlock, she will simply say " Time, gentleman," and walk off without hesitation or regret, leaving you to it. And to your idiomatic but plaintive gasp of " What do you know about that ? " she will fling over her shoulder to you the mocking but accurate reply " Nothing."

Wonder, on the other hand, far from running away from the situation, will view it with equanimity and feel she is on familiar ground. Very often, indeed, she will offer to introduce a near relative called Faith, whom you may or may not have met before. (" One of the real old family, I mean, of course. So simple and sincere. Very intelligent but not bookish, if you know what I mean. No connection of the Faiths that married into the Credulity family and keep telling stories about whales.") Between them they may convince you that the word " Go," which frightened Dame Science away, was merely the warning to get under the Starter's orders for the greatest and most hopeful adventure of all. They will certainly try to, if you allow them.

[1] Yes, perhaps I should have called it a running dive.

APPENDIX: SANE PSYCHOLOGY

[I originally intended this Appendix to be Chapter 1, but relegated it to its present undistinguished position on having it made clear to me that it is not obviously related to the rest of the book, is not addressed to students, and contains material that may be of no immediate interest or value to them. I could not exclude it altogether because it is a survey of the situation which prompted and, I think, justified the writing of the book, and a review of the events leading up to that situation.]

SOME years ago, in one of his wittiest speeches, Sir Robert Hutchison made a startling reference to that Last Great Day when the earth shall quake and the rocks melt, the sun be turned to darkness and the moon to blood. He could prophesy with confidence, he said, that whatever remarkable happenings might be observed on that day, they would certainly include the spectacle of a strong committee [1] seated round a table engaged in revising the medical curriculum.

In spite of the prodigious efforts which are being made in the matter at the time of writing, and the revolutionary changes which we are told the next few years will witness, Sir Robert's prophecy may still, one imagines, be regarded as a pretty safe bet by all who retain their sense of proportion and can look backwards as well as forwards. The man who "hath forgotten" is, as St. Peter reminds us, the man who "cannot see afar off," and very naturally so. One can hardly be blind in one direction only.

The place of psychological medicine in the student curriculum and the methods by which it should be taught are points on which attention is most keenly centred and around which discussion rages most furiously at the moment. There is practical unanimity of opinion among all concerned that more time and attention should be devoted to the subject; but there the unanimity ends abruptly and is replaced by a chaotic welter of vague generalities, pious hopes, faddist theories, complicated schemes and futile proposals, plus just a suggestion, here and there, of a little private axe-grinding.

[1] In the excitement of the moment, Sir Robert used the phrase "a company of greybeards." I have ventured to paraphrase his actual words, without, I trust, departing too far from his meaning.

The reason of all this is not far to seek. No individual or committee appears, so far, to have been able or willing to state just what it is that the student is to be expected to learn. The inherent complexity of the subject, its vast scope and its supreme importance in medical practice are being more clearly realised every day, and make obvious the urgent need for assessing its claims fairly and defining its limits clearly, in relation to the medical student. It is not a question of allotting a few hours more or less to lectures or demonstrations on a subject. It is a major problem of urgent importance to which the eyes of medical school authorities and others are only now being slowly opened. It is admittedly also a problem of extreme difficulty, but that very fact makes all the more obvious the necessity for a calm and unprejudiced survey, the collection of data, the establishment of common ground, and the formulation of an agreed general policy. That is the scientific method of dealing with a problem, no matter how difficult or even insoluble it may appear. But, with all the complexities admitted, it may well be urged that the task of agreeing on a syllabus should not present insuperable difficulties to men of experience and goodwill. Once that were accomplished, the questions of the method of teaching, the time to be given to it and so forth, could also be worked out easily enough.

Unfortunately, it is not merely a question of agreeing on a syllabus. The problem is a much harder one than that. Let us try to clear the ground a little by isolating a few of the essential facts.

Psychological medicine is a specialty, and a very difficult and complicated specialty at that. A majority of qualified physicians would probably admit that they left their medical school knowing little about it. Some would add that they have learned nothing about it since, and a few are still to be found who make such an admission with pride rather than shame.

On the other hand, one can hardly open a medical journal nowadays without finding a letter or article pleading for closer union between general medicine and psychological medicine, and paying a handsome tribute to " the psychological factor." This remarkable factor has been vanishing from medical thought and reappearing therein at irregular intervals since

the dawn of civilisation. Its history resembles that of the immortal Cheshire Cat, and it has every right to the grin which was so characteristic of that animal. Its latest reappearance is being hailed, like all its previous ones, as a notable advance in medicine and, under its new title of " psychosomatic unity," it is enjoying a splendid " write-up " in medical literature by erudite authors who, it is only fair to say, rarely fail to make the usual acknowledgments to Plato.[1]

No elaborate argument is needed to demonstrate the unique position of psychological medicine among the specialties. Cardiology, gynaecology, dermatology, to name but three, are specialties which can get along nicely without much help from each other, but nobody can practice any of them for long without certain misdiagnosis, probable mal-treatment, and possible disaster unless he has a working knowledge of medical psychology which goes beyond mere polite acknowledgment of " a psychological factor."

The simple central fact is that, as well as being a specialty, psychological medicine is an essential constituent part—not a handmaid or a poor relation—of all branches of medicine. If " psychosomatic unity " means anything at all it is hard to see how this could possibly be otherwise. But this fact places us in a dilemma from which there is no escape. It seems to indicate clearly that we must give the student a grounding in psychological medicine which will be commensurate with its importance, and which will certainly be comparable in its extent and thoroughness to that which he receives in medicine, surgery and midwifery. To do this, however, would be to swamp the whole curriculum with a flood of psychological instruction, and to produce graduates whose knowledge of the specialty would far exceed that of the average present-day holder of a Diploma in Psychological Medicine. This is clearly out of the question. It can never be the object of the medical curriculum to turn out specialists in any department of medicine.

Faced with this difficulty let us try to formulate clearly our minimum obligation to the student—the instruction for which

[1] " This is the greatest error in the treatment of sickness that there are physicians for the body and physicians for the soul, and yet the two are one and indivisible."—*Plato.*

we *must* find time and opportunity in the curriculum, somehow or other. In the first place, we owe it to him to give him such instruction in the subject that on graduation he shall have a sound basis for post-graduate study should he desire to specialise. Secondly, we owe it to him that on graduation he shall be able to judge when specialist help is required and shall be able to avoid gross blunders in procedure, diagnosis or treatment in the absence of such help. But we have a third obligation which, unlike the first two, applies to this specialty alone. We owe it to the student—and, for that matter, to the public and to the whole science and art of medicine as well—to give first priority in all our teaching to anything and everything in the subject which illustrates and emphasises its intimate relation to—its essential unity with—all other branches of medical study. If the universal insistence on that essential unity has any meaning and sincerity we must do this, even at the cost of cutting out matter, however important, which is peculiar to the specialty and without direct bearing on general medicine.

We cannot discuss how we can fulfil these obligations without first considering the nature and scope of the specialty in more detail.

"Psychological medicine" is a comprehensive term. It includes, among much else, the study of the etiology, pathology, symptoms and treatment of the psychoses, the neuroses, mental deficiency, and other less clearly defined states. Some of these studies have led to the discovery of vast new fields fields for medical activity and research. The pathology of the neuroses, for example, has been found to be a psychopathology, and the great systems of psychotherapy based upon it are specialties within a specialty. The same is true of mental deficiency and child psychology. The elucidation of psychopathological principles and mechanisms has revolutionised medical psychology and linked it up with social medicine and public health by means of such great specialties as industrial psychology, vocational psychology and the like.

Finally, the field for research has never been so vast and varied as it is today. In particular, the results achieved by the scientific study of brain physiology and its application in various treatments have been brilliant, and hold out hope of even better things to come.

Now, to what part or aspect of all this does the plea for closer union between psychological medicine and general medicine relate? It has repeatedly been pointed out that modern medical practice is tending to become more and more a matter of chemical tests, laboratory procedures, mathematical calculations and pointer readings. This is, of course, inevitable as knowledge increases and technique improves, and the accuracy and helpfulness of the information gained in such ways is not for a moment in dispute.

But this development carries with it the equally inevitable drawback that the more a student learns of these procedures and their undoubted value, the less will he find any opportunity or see any necessity for training his unaided powers, and thus developing what used to be called " a clinical sense." To fail to X-ray a fracture, for example, is unpardonable, and the use of X-rays makes possible an accuracy of diagnosis which was unheard of before their discovery, as well as ensuring a much higher proportion of good results of treatment. But it follows that the student of today does not possess and can never acquire the sureness and delicacy of touch, the manual dexterity, or the unaided diagnostic powers of the practitioner of fifty years ago. It may be said that in the instance given this is no great loss, as a doctor will very rarely be completely cut off from X-ray facilities nowadays. Such occasions do arise, nevertheless, and, in any case, the principle is far wider than the illustration. It is not good for the student to feel that the position of the hospital physician resembles, of necessity, that of a judge or assessor who studies the value and relationships of a mass of typewritten reports from pathologist, radiologist, bio-chemist, haematologist, and so on, and finally pronounces a diagnosis largely based on their collective significance. Its worst effect on him is to make him feel free from any real obligation to devote much thought or effort to the personal investigation and examination of a patient so long as a secretion or function remains untested by the experts of a clinical laboratory or a special department. We are all sadly familiar with patients who perambulate wearily round a hospital from department to department like a " passed to you " memorandum in a Government office. The effect on the patients is bad, but the effect on the students is in many ways a great deal worse.

All this has, of course, been pointed out often enough in recent years, but little or no attention has been paid to the fact that precisely those tendencies which so many observers have noted and deplored in general medicine are to be seen even more clearly in psychological medicine in which they are growing and flourishing, with less justification and, if possible, more harmful consequences.

Even the not so very senior among us can recall the days when the contribution of psychological medicine to the curriculum was the modest one of ten or twelve lectures on the more blatant forms of psychosis, plus comic relief in the form of a few "asylum visits." The unfortunate lecturer was all too often regarded by students and colleagues alike as a man who had chosen his specialty in an effort to conceal his incompetence in any branch of "real" medicine, while at the same time indulging his fondness for a little rough shooting and occasional secret drinking. It is sad to have to record that this attitude persisted long after psychiatry could point to a list of "asylum men" of such ability, distinction and character that the whole profession might be proud to do them honour. It is still sadder to have to say that it is even yet to be met with, and that some of the medical planners who have most to say about the future of psychiatry and its teaching are by no means guiltless of helping to perpetuate it.

It is interesting to outline the development of psychiatric teaching from the stage referred to. The specialty had a unique opportunity of coming into its own in the years immediately following the first world war, when the immense scope and practical importance of what was then known as "the New Psychology" first became apparent to the more intelligent members of the medical and general public. The doctrines of the new psychology had been seeking recognition and inviting application and research since the beginning of the century. The war of 1914–18 brought them vividly to public notice and provided psychiatry with such a chance as may never return to effect the union between psychological medicine and general medicine once for all, and, by so doing, to become the Queen of the specialties instead of their Cinderella.

This chance was totally lost—some would say it was thrown

away. It would be unprofitable to discuss how and why this occurred, or to attempt to apportion the blame. Suffice it to say that the golden opportunity was wasted, that the new psychology became a byword and a hissing among the teachers and practitioners of general medicine, and that the concept of psychosomatic unity retired, hurt, to very cold storage for about twenty years.

Psychiatry was thus faced with the choice of continuing to vegetate in the seclusion of the asylum or of struggling towards general medicine by way of the only bridge left open to it. The bridge was a strong and highly respectable one. Organic neurology was ready and willing to escort psychiatry across the gulf. This willingness had, indeed, been apparent for many years, and so keen had her desire to be of assistance become that, rather than leave Psychiatry in her Slough of Despond, Neurology was prepared, if all other means failed, to carry her across the gulf on her own broad back.

Psychiatry had little choice in the matter. Like the church of the Laodiceans she knew not that she was wretched and miserable and poor and blind and naked, but the fact was very soon made plain to her. She had no firm foundation of histology or pathology—or if she had, it was really Neurology's property. In her own right she had only a so-called psychopathology which was purely theoretical, and impurely Freudian. Her diagnoses were merely descriptions, her classifications meaningless, and her clinical studies, therefore, a waste of time. Her methods were pitifully out of date, and as for her researches and her advances in treatment, the only important ones were neurological, and, though Neurology had not happened to make them herself, the sooner they were handed over to her care the better.

So Psychiatry delivered up her heavy luggage as requested, and, with her escort, set out on the journey to meet "general medicine." She carried a few personal belongings herself, as an old lady clings pathetically to the handbag containing her private little possessions and treasures. They consisted mainly of barren and threadbare remnants of medical psychology, too old to be fresh and vital, and not old enough to be true antiques, but very useful to have about one in case one had to say something about "the psychological factor" at a consultation or in

of G.P.I. he did—take an active part in the effort to establish the pathology of all the disorders with which he has to do, and to found thereon classification, diagnosis and treatment, be they what they may. Let us therefore consider a disorder the pathology of which has not been satisfactorily established, namely, schizophrenia.

In the bad old days the name Schizophrenia and even the name Dementia Praecox were alike unknown. There was just "adolescent insanity," some cases of which recovered while others did not. Armed with nothing but their experience and their clinical insight the older psychiatrists used to put a given case into the favourable or unfavourable group at an astonishingly early stage, and forecast its course with almost uncanny accuracy. Kraepelin finally isolated the unfavourable group and gave it the name Dementia Praecox. Its separation from the adolescent insanities with a more hopeful prognosis was made on purely clinical grounds which Kraepelin expounded with infinite care and in great detail. This clarification of the position, however, had no great or lasting effect in simplifying the task of true differential diagnosis. On the contrary, a gradual falling off in clinical acumen, or at least a growing tendency to sit too long on the diagnostic fence, became apparent.

The next development was the substitution of the name "Schizophrenia" for the name "Dementia Praecox," but this was more than a mere verbal alteration. The new word had a much wider connotation than the old one, and soon became universally accepted not as a name for, but as a diagnosis of, any adolescent psychosis which was not frankly a manic-depressive one. It thus became a labour-saving device of great popularity. The whole trend of medicine was towards the view that until there is a sound pathology on which to base them, laborious efforts at classification and diagnosis are a waste of time. This summary sweeping aside of Kraepelin's clinical refinements and the substitution of an almost unmistakable syndrome on the one hand and a diagnostic rag-bag for everything else on the other, was therefore hailed with enthusiasm by the younger and possibly more scientific psychiatrists as providing a way of escape from much pointless drudgery. The fact that such an attitude is perhaps hardly characteristic

of science at its best appears, unfortunately, to have escaped general notice.

The next and last step, which brings us up to date, was the introduction of the modern curative treatments. These are all essentially empirical. The treatment of a disease which has no pathology cannot possibly be anything else, however wide the scope for theory and research which it may offer. They have had brilliant successes and inexplicable failures in almost every known form of mental disturbance, they are not demonstrably harmful in any, and they entitle physician and relatives to feel that at least "something is being done." And so we reach the last phase in which the demands of diagnostic and therapeutic effort are alike satisfied by referring to "a schizoid element in the personality" and pressing an electric button. We see, therefore, in our two illustrations—G.P.I. and Schizophrenia—how the atrophy and death of personal clinical study and individual diagnostic effort in psychiatry can result from two directly opposite sets of causes: the establishment of organic pathology, laboratory diagnosis and logical treatment in the one case, and the entire absence of anything of the kind in the other.

Now it may well be argued that the abandonment of this study and effort is not in itself so very deplorable. It is, no doubt, a pity that psychiatry is becoming less clinical, but the tendency is an inevitable one in which general medicine shares, and there are many compensating gains. After all, if better, surer, or quicker results can be obtained by other means, psychiatry can hardly be blamed for laying aside her elaborate symptomatic classifications and her laborious descriptive diagnoses.

But in laying them aside she has also abandoned the methods that produced them and the foundations on which they were based. It may be a relatively small matter that they have been superseded, but what of the intimate personal knowledge of the individual patient which lay behind them? The old psychiatrists did not make a "ward round" or "hospital visit" on three or four days a week. They visited their patients day in and day out, morning, noon and night. They made friends of them, they knew their Christian names, they knew their families and relatives, they entered, in short, into every detail of their lives. Doubtless these foolish old doctors wasted much valuable

married or single, Briton or Hottentot. He assumes, very naturally, that such things cannot possibly affect the soundness of the diagnostic and therapeutic procedures, the skill with which they are applied, or the results of the laboratory tests. But every now and then the patient happens to react otherwise than as a glorified biochemical laboratory, and ceases to behave " according to plan." Such occasions would seem, one imagines, ideal opportunities for giving some elementary information about " psychosomatic unity," but the more usual procedure is for the teacher to announce the discovery of a " psychological factor " in the case as if it were a foreign body, or some new planet that had swum into his ken. He then says a few words about " excluding the organic," and transfers the patient to the psychological department. " And all his men looked at each other with a wild surmise."

It is undoubtedly the business of the teachers of medical psychology to ensure that the student shall make the human approach the basis of his contact with his patients, but it is painfully clear that they have so far failed to do so. The task, let it be admitted, is an almost impossible one. Both medicine and psychology are becoming not only less clinical, but less human ; much of the " medical psychology " the student learns is simply—and necessarily—a grounding in and preparation for the study of nervous and mental disorders which he will undertake later in his course, and the rest is formal, general and theoretical, containing little more than psychological principles, stock illustrations, and schedules, lists and diagrams to be got by heart.

Now the greatly desired " sane psychology " is the application of these principles to medical thought and work, and much of it is teachable, if at all, only by example and experience. Small wonder, then, that in the lectures allotted to the subject most teachers confine themselves to the general principles, which, after all, have got to be learned, and learned well, and leave their practical everyday human application severely alone. The problem before us is so to expound and expand and apply these principles that they shall serve not as the elementary part of a course in psychiatry or psychology, but as an introduction to an outlook on medicine and on life which every student should possess and which would be the most

essential and effective part of his equipment for any branch of medical practice.

If the foregoing is in any way a fair appreciation of the situation, then it follows that the task before the reformers of the curriculum is one of unique difficulty.

It is something far bigger than merely deciding on a syllabus, nor has it any real relation to such minor considerations as the number of lectures to be given, the stage of the curriculum at which they should be given, and so on. The question of how much psychiatric or psychological knowledge the student acquires is secondary, and indeed almost irrelevant, to the question of how we can help him to acquire the human approach to his patients, which always transcends, though it never contradicts, his scientific approach to his " cases."

Mindful of Sir Robert Hutchison's prophecy, I refrain from adding my personal opinions to the counsels and activities of the reformers. I would venture, however, to offer them one gentle reminder, with great respect. All history shows the futility, in great schemes or small, of imagining that change of environment will of itself produce change of heart, and that improvement in external conditions will necessarily be followed by diminution in human weakness and folly. In the same way, we may be very certain that no amount of tinkering with the medical curriculum will be of any avail unless it is associated, somehow or other, with close and careful attention to the individual personalities of those who teach and of those who learn.

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